

WINTER 2002

# Harvard Medical

ALUMNI BULLETIN



## **BAD** **CHEMISTRY**

When doctors and  
patients just don't mix



#### LUMINARY

Francis D. Moore (1913–2001) helped train more than 1,500 surgeons during a career celebrated for scientific accomplishment and outstanding ethics.



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## BAD CHEMISTRY: WHEN DOCTORS AND PATIENTS JUST DON'T MIX

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Cover illustration by James O'Brien

## In This Issue

**E**MPATHY HAS A BAD NAME. THE SOUND ITSELF IS GOOEY, FLABBY. AS A word it keeps unsavory company. "See Synonyms at pity," says my dictionary—"pity" in boldface. The reality is that empathy is a job for the head over the heart. It requires intellectualization, imagination, and some experience of life. It is a skill as much as an attribute. And with the best of intentions, it is a skill that fails us from time to time. In this issue, several of our contributors reflect on encounters that test or defeat a physician's ambition to empathize.

One of the chief barriers to learning and practicing empathy is the tendency to sentimentalize it. Empathy is a mental tool, as useful to con artists as to counselors. The character of Counselor Deanna Troi in the TV series "Star Trek: The Next Generation" is a particularly irritating example of empathy turned to treacle. The psychiatrist Jennifer Melfi, carefully treating the Mafioso Tony Soprano, sets a better example, on the whole, of dispassionate empathy. So, for that matter, does Hannibal Lecter, the ultimate combination of astute psychiatrist and absolute sociopath.

Not quite paradoxically, one's own emotions—fear, for example—can become traps along the way to empathy. Understandably, there's nothing like the behavior of a threatening patient to shut down one's curiosity about the mental processes behind the activity. Regrettably, a rapid effort to contain or restrain the frightening person can often make the situation worse. And mere anger in a patient can be daunting enough. As a person with chronically rising gorge and dudgeon set permanently on high, I find that anger in patients is always a test of my ability to tolerate both their feelings and my own for long enough to think through the problem, whatever it may be.

Even when we are armed with self-awareness and liberated from unruly emotions of our own, certain patients may defy our best efforts to get what they are about. Intoxicated patients leave me clueless, perhaps because they are not, in fact, themselves. Vivid memories of childhood fevers, on the other hand, give me some sense of what delirium is like. And yet there are people who are neither intoxicated nor delirious, but living in a mental place where empathy seems impossible. Perhaps the greatest literary illustration is Herman Melville's tragic Bartleby, a disabled scrivener for whom compassion, though abundant, is useless because, willy-nilly, he makes empathy impossible.

Missing in this issue are the voices of patients. The point of view is the physician's. This is because, like doctors, publications cannot be all things to all people. In this issue, then, we offer some modest attempts to note the limits of our efforts and ability to be perfect physicians.

*William Ira Bennett*

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## DOCTORS ON PARADE

I certainly enjoyed the Summer 2001 issue of the *Bulletin* with the cover photograph of our classmates in Army uniform. I recognized many of the student-soldiers, including Steve Deckoff, Ward Orrahood, Frank Egloff, Bruce Fisher, John Gray, Loomis Bell, and John Wiggin. I was ninth in line for whatever it was we were being served. The photo was taken in 1944 when we were in the latter part of our first year and most of us were between 19 and 21 years old. I don't recall the specific occasion of our being fed from the Army truck, but I remember well the weekly "parades" when we marched in front of Building A, many of us out of step. We were a pretty sorry bunch of soldiers and Major Rosengard had the impossible task of getting us to "shape up."

The photograph includes only those of us who were in the Army Student Training Program, which was about half of our class. We were envious of those who were in the Navy V-12 Program. They wore handsome midshipman-type uniforms and had a more relaxed military lifestyle.

All of us, however, were aware of how fortunate we were to be in the protective environment of HMS while many of our college classmates were risking their lives to defend our country. This led to our becoming the close knit group that still exists.

Incidentally, most of us eventually served as medical officers in the Army and Navy during the Korean conflict. We were proud to have that opportunity to pay, in a small way, our debt of gratitude for the safety and happy times we had enjoyed at HMS during the World War II years.

Thank you for including the Class of '47 in your most interesting issue.

JAMES M. DAVIS '47  
JACKSONVILLE, FLORIDA

## Silent Heroes

I enjoyed the summer issue of the *Bulletin*, "What Did You Do in the War, Doctor?" It was particularly meaningful because I am in the process of writing an answer to that question for my grandchildren. For many years I was unable to talk about my experiences, as were many veterans.

Almost half of my medical school classmates were at least 28 years old. Many of us had made the deliberate choice to put medical school on hold in order to serve in the war. Many had seen combat. We were older, seemed different somehow, and rarely spoke in the first person. One ex-Marine, for example, was reluctant to tell about the horrors he had endured. Vanderbilt Hall was full of vague allusions but not many details: Did you know that so-and-so was a Marine at Guadalcanal? That so-and-so was a fighter pilot off a carrier? That so-and-so came out a full colonel?

One of the statements that Bill McDermott '42 made in that issue—"We weren't heroes at all. We were just doing what was right and what had to be done"—was exactly right. We who were lucky and blessed to come back didn't feel like heroes. Those who didn't make it were the real heroes.

SHELDON M. LEVIN '50  
SAN FRANCISCO, CALIFORNIA



E. Langdon Burwell '44

### Photographic Memory

You may be interested to know that the lead student in uniform in the photo of students participating in a chemical warfare drill is E. Langdon Burwell '44, who passed away in 1993.

JONATHAN B. HORRELL '44  
OAKLAND, CALIFORNIA

### The Forgotten War

May I compliment you on the special report, "What Did You Do in the War, Doctor?" The report was especially timely in view of the events of September 11.

I'd like to add a few words about action in the China-Burma-India theater, which has sometimes been described as the "forgotten war." Having been a surgeon with the U.S. Army 22nd Field Hospital in China from 1943 to 1945, I humbly believe that our experiences in China must be remembered in view of political, social, medical, and military considerations.

I went to China as part of a U.S. Army contingent of 750 officers sent over to train Chinese forces. When I enlisted, I was only 25 years old, barely out of HMS, so I brought all my medical and surgical textbooks with me. Of course, we didn't have all the fancy equipment commonly used at Peter Bent Brigham Hospital available to us at the front, so we really had to sharpen our skills in the art of taking a thorough history and doing a very rigorous physical examination—skills that would prove useful to me in my postwar civilian career.

When my unit was called for active field duty as a portable surgical hospital, we traveled toward the front lines almost entirely on foot. Walking up to ten hours a day over narrow, rough trails, we climbed mountains that took five days to ascend and relied on wooden-saddled pack animals to transport our limited supplies. We set up our first operating room under a clump of trees on a sandy riverbank, where we carried out one major surgery after another, eschewing operating gowns and saving precious gloves for abdominal, brain, and thoracic procedures.

After several days, we crossed the river to follow our fighting units. We moved through monsoon-swollen streambeds and over paths so high that we found ourselves above the clouds—our lungs felt as though they were splitting apart. While the Chinese soldiers displayed amazing endurance, even carrying loads of our equipment on their backs when the going got too steep for the animals, most of the Americans lost 10 to 20 pounds.

We eventually set up our hospital in a Chinese nunnery, where our carpenter transformed a place of worship into a crude operating room. To the tall pillars supporting the roof we nailed boards from which we hung bottles of intravenous fluids. In addition to soldiers, many civilian victims of the fighting passed through our wards. The peasants refused to abandon their rice paddies and livestock and often found themselves in

the path of stray Japanese bullets or even friendly fire. I remember operating on one woman in particular who had been shot in the thigh and whose one-year-old baby had been hit in the knee.

Although decades have passed, I will never forget caring for the wounded during the Salween Offensive, when I saw the lethally injured die, observed their bodies being buried near the Salween River, then watched those bodies being washed downstream by the swollen, roaring water. Nor will I ever forget my experiences at the front at Tenchung, where 2,600 Japanese were killed.

But, as horrific and tragic as the consequences of war are, we should heed the lessons of Pearl Harbor and September 11: in peace, as in war, it is always crucial to know the enemy and to be prepared.

WESLEY L. FURSTE, II '41  
COLUMBUS, OHIO

### Articles of War

I always get a charge out of pieces on Harvard during World War II, such as the excellent articles in the Summer 2001 issue. I applied to medical school in 1966 while on active duty in the Navy. When I wrote for a Harvard application I was politely told that Harvard did not accept applications from individuals on active duty. Makes you proud, doesn't it?

WILLIAM R. WELCH, MD  
BOSTON, MASSACHUSETTS



### HUMBLE HERO

I knew William McDermott '42 when he was an iconic figure in the great HMS Surgical Service at Boston City Hospital. I concur with Editor-in-Chief William Bennett's respectful disagreement with Dr. McDermott's statement that he and the other soldiers weren't heroes at all, but were just doing what had to be done.

VELANDY MANOHAR, MD  
HADDAM, CONNECTICUT



## THE HEART OF THE MATTER

Y

our interesting summer issue on World War II brought to mind the amazing wartime story of one of my HMS classmates, **Douglas Stone '37**. In 1944, during the Normandy campaign in World War II, Dr. Stone and his surgical team performed successful open heart surgery to repair a seriously damaged, lacerated heart in an injured soldier. Operating in a muddy, abandoned German tank pit amid ferocious battle conditions, Dr. Stone and his team managed to save the gravely wounded soldier. The patient was not breathing, had no pulse, and had a wound of the upper right chest that had been stuffed with a piece of GI raincoat to prevent the sucking action. I thought your readers might be interested in an abbreviated account, in Dr. Stone's own words, of that dramatic surgery.

ALBERT ENGLAND '37  
LINCOLN, MASSACHUSETTS



### Miracle at Normandy

The patient was unable to breathe on his own. Our anesthetist immediately applied a mask to the patient and began artificial respiration, which also helped to inflate the remaining functional lung, the other having collapsed. Simultaneously, one of the technicians swabbed the chest wall with antiseptic solution, then soaked his hands and became our instrument man. I quickly threw four sterile towels around the wound site and made an incision directly through the skin wound. It was necessary to rapidly remove sections of four ribs to give myself room in which to operate.

The chest cavity was full of blood, and I had to bail it out by the handful. Our technicians got the suction working, which allowed me to see the damaged area. They were unable to insert needles into the collapsed peripheral veins to give the crucial blood and electrolyte fluids. I told them to remove the blood pressure cuff from the patient's arm and to wrap it around the blood donor bag. This improvisation was in anticipation of the need to force the blood steadily through the tube into the heart.

By this time, I had the heart exposed and moved gently to the patient's right. The critical wound was an elongated vertical gash into the right ventricle, now barely oozing blood. I plugged the gash with my right index finger along the wound and, while holding the flaccid heart in the same hand, gently massaged it. With my left hand I took the large donor needle from the technician, having to

ignore the "sterile" technique, and inserted it into the right atrial chamber of the heart. Three liters or more of blood were given as rapidly as possible. The effect was magical. Veins grew visible in the arms, and more blood was started in them.

With my finger still plugging the deep gash, I took a large, curved Bloodgood suture needle in the left hand, passed it deep through the full thickness of the heart muscle on one side of the gash, under and around my finger and out through the full thickness of the heart muscle on the other side. This was done quickly four times in a row. Then, as I slid my finger out, my assistant gently pulled up all four sutures. I quickly tied square knots in each suture one by one, snugly, but not tightly. Over this incision I sutured a flap of pericardium to cover and support the closure. The sac itself was not fully closed for fear a possible accumulation of blood into the empty sac might compress the heart and inhibit its action or cause localized infection.

After closure of the heart wound had been completed, I resumed cardiac massage to the flaccid heart muscle and could feel it perceptibly firming up and fibrillating. Soon a little rhythm or beat was detectable. As I continued this action, the patient began to change color from paper white to pale pink. His veins were filling up, so now they could be used to give additional blood more rapidly. We all gave a heartfelt sigh of relief. We knew we had won the all-important first round.

By now all bleeding had stopped. The patient had received and retained an estimated five liters of whole blood, was showing an even better color, and had a detectable pulse. Finally, we checked around the chest cavity for "bleeders," using the suction apparatus to empty all fluid and to get a "dry" chest. A couple of hemostatic sutures were quickly placed in a shallow laceration of the right lung. We then inserted our drains through stab wounds into the chest cavity, instilled 40,000 units of penicillin into the chest, sprinkled sulfanilamide powder into the chest and tissues, and carefully closed the incision in layers.

In 1995, while my wife, Essie, and I were on an automobile trip through the West, we made a search for the patient, Terry, and found him in his comfortable home in Iowa. He was doing well at age 71. Terry told me that in 1994 during one of his many checkups, a cardiologist remarked that the operation could not have taken place, because open-heart surgery had not been published in the surgical journals until 1959.

God was with Terry those many years ago and I pray that He always will be.

*Douglas Stone '37, now retired, practiced surgery for more than 35 years in Baltimore, Maryland, and Asheville, North Carolina. This excerpt is reprinted with the permission of the Maryland Medical Journal (March April 1999; vol. 48, no. 2).*



## Drug Deals

The Summer 2001 issue of the *Bulletin* includes an erudite article by David Shaywitz and Dennis Ausiello on “the nature of medical breakthroughs” that features the statins. However, it is possible to interpret the discovery and popularization of statins quite differently.

Let us begin with their Lesson One: “Academia and industry are symbiotic.” This is undoubtedly true. Big Pharma rules. And their bottom-line rule is “We support academics in order to find blockbuster drugs, then we promote those drugs relentlessly to develop an unassailable consensus position that can overwhelm/delay other effective but less profitable therapeutic alternatives.”

Perhaps that is why we had to wait for remote Australian researchers to uncover the gastroduodenal ulcer connection to *Helicobacter pylori*—a connection that Big Pharma (and any academics they could hold in thrall through research grants or peer pressure) missed and then ignored, thereby delaying definitive antibiotic therapy for most patients for many years. Eventually, it was not academia but the Centers for Disease Control and Prevention that publicized this safe, definitive, and far less costly treatment.

Similarly, the authors cite the most popular statin as a billion dollar drug, yet they admit that its apparent benefi-

cial effect may hardly relate to cholesterol lowering at all. Of course, it takes hype to survive in a field of costly me-too drugs that may or may not act beneficially (all statins do have severe and even fatal side effects, as Bayer recently acknowledged). So at appropriate intervals, the medical-industrial complex has released announcements such as, “Statins may also be anti-inflammatory!” (like aspirin?) and “They may delay dementia!” and “They may even combat bone disease!” Or maybe not. But for whatever reason, just keep prescribing those costly drugs until our patent runs out.

My point? Inflammation is a sign, not a disease. In the stomach it was finally attributed to *Helicobacter pylori* after years of profitable delays. Similarly, it took a remote Finnish researcher to determine that *Chlamydia pneumoniae* DNA was present in the majority of diseased coronary arteries that he examined. And once again, the tremendous health improvement potential of this repeatedly confirmed finding has largely been ignored, except by a few academics running large well-funded long-term studies that won't report back for years (until the patent runs out?).

In the meantime, we are urged not to try tetracycline or other equally safe and cheap (20 cents a day) antibiotic treatments for coronary artery disease

because it might not help and “there is a high risk of bacterial resistance from antibiotic overuse.” Apparently, some academics consider a few unauthorized, potentially life-saving tetracycline applications far more likely to induce resistance than the thousands of tons of antibiotics routinely used in animal husbandry.

On a personal note: I am a retired heart surgeon who underwent a six-vessel coronary bypass in 1983. Three years ago I developed angina at rest, which persisted unchanged, without treatment other than my usual atenolol and aspirin, for two weeks. After considering all options, I started myself on tetracycline (half a gram twice daily) and within eight days was once again chopping trees (slowly). I have since remained on that inexpensive anti-inflammatory antibiotic regimen without experiencing further coronary problems. I would ask any alumni who have had similar experiences, or who derived no value from antibiotic treatments for coronary ischemia, to share their information with your readers.

ARNDT VON HIPPEL '57  
ANCHORAGE, ALASKA

## The Stress Factor

I feel quite strongly that the role of cholesterol in contributing to heart disease is overemphasized. I am not a cardiologist, but in my own case, in the case of family members, and in the course of treating many patients with heart attacks and coronary heart disease, I feel that stress is a far more important factor.

I also believe that education does little to get rid of tobacco smoking, but raising the price of cigarettes does wonders.

ROWLAND FRENCH '43B  
EASTPORT, MAINE

## Giving Unions Their Due

I read with great interest “Stand & Deliver,” the article by Joshua Sharfstein '96 and Yngvild Olsen '96 on the difficulties faced by pregnant residents. I found it remarkable, however, that the article



did not mention the most successful method to date in creating change in the work hours and leave policies in residency: resident unions.

As a member and president of one of the largest and oldest resident unions, the University of Michigan House Officers Association, I have seen firsthand the benefits of an organized voice for house-staff. Our current contract provides for guaranteed paid maternity leave of six weeks (with the option to take an additional six weeks of unpaid leave) and no overnight call for the third trimester of pregnancy and for two months postpartum. Contrary to the presumptions made in the article, these special exceptions for pregnancy have been widely accepted by house officers and faculty alike.

In addition, for more than ten years, our house officers have been entitled to guaranteed days off each month, long before the Accreditation Council on Graduate Medical Education even began to adopt policies on resident work hours (which to date still are largely unenforced). Our 28 year history of success at Michigan has shown that resident unions have been and will continue to be at the forefront in addressing the problems in the current system of residency training. As the direct voice of resident physicians themselves, resident unions

remain committed to the betterment of residents' lives and, as a direct consequence, the improvement of patient care and resident education.

VIKAS I. PAREKH '99  
ANN ARBOR, MICHIGAN

## Hard Labor

Drs. Joshua Sharfstein and Yngvild Olsen's plea to make residency training more "humane" and to be treated more "fairly" will, I fear, fall on deaf ears unless they have some concrete suggestions as to how hospitals can meet three demands: patient coverage, costs of employment, and adequate training experience. With so much outpatient care, the last of these three is particularly difficult, but the decrease in federal support for medical education is also hard to overcome.

More surprising, however, is their suggestion that being a doctor and having a normal life—which, I assume, means everything can be scheduled and the workweek is about 40 hours—are compatible. I've never met anyone entering medicine who thought they would live like their nondoctor friends. The educational process and the life requirements are all different and stressful, unless you love what you're doing. We all know that the incidence of divorce, alcoholism, drug

usage, and suicide are greater in doctors than in comparably educated nondoctors. That is a reflection of the kind of people we pick to become doctors as well as the stress of the lifestyle.

One question: Was Dr. Olsen thoughtful enough when she went into labor to do so at 9:00 a.m. and complete it by 3:00 p.m. so her obstetrician could get home to dinner and see his or her children? Would she have been just as happy to have her doctor say goodbye and let someone else do the job when he or she went off duty on schedule? Especially if there were problems or complications? Welcome to the profession, Drs. Sharfstein and Olsen. I'll await your solutions when you are heading up a residency program. Medicine is not easy unless you love it.

ALAN R. SPIEVACK '59  
CAMBRIDGE, MASSACHUSETTS

*The authors respond:* We did not write—and do not believe—that medicine is a nine-to-five job. However, we also disagree with the idea that medicine must be a nine-to-five-the-following-day job. We support the hours restrictions recently put forward by the American Association of Medical Colleges, which would limit resident shifts to 24 hours and cap the workweek at 80 hours. These reasonable guidelines now need to be adopted and enforced by accrediting organizations.

JOSHUA SHARFSTEIN '96  
YNGVILD OLSEN '96  
BALTIMORE, MARYLAND

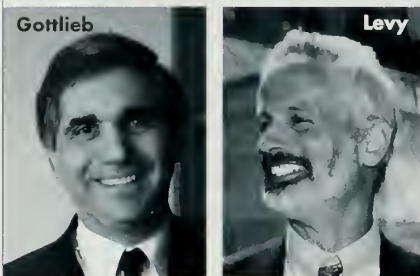
## A Midsummer Nice Read

I just wanted to congratulate you on the excellent Summer 2001 issue of the *Bulletin*. The cover alone was so stirring, and the pieces were fascinating.

ED COBURN  
BOSTON, MASSACHUSETTS

*The Bulletin* welcomes letters to the editor. Please send letters by mail (Harvard Medical Alumni Bulletin, 25 Shattuck Street, Boston, Massachusetts 02115); fax (617 384-8901); or email ([bulletin@hms.harvard.edu](mailto:bulletin@hms.harvard.edu)). Letters may be edited for length or clarity.





## Hospital Leadership

New hospital presidents were recently announced at Brigham and Women's Hospital and Beth Israel Deaconess Medical Center.

Brigham and Women's named Gary Gottlieb, HMS professor of psychiatry and chairman of the Partners Psychiatry and Mental Health System, to serve as the hospital president. He will replace Jeffrey Otten, who announced in November his intention to step down after nine years at the hospital. From 2000 to 2001, Gottlieb served as president of North Shore Medical Center; before coming to Massachusetts, he was director and chief executive officer of Friends Hospital in Philadelphia.

Paul Levy, HMS executive dean for administration, was unanimously selected by the Board of Trustees at Beth Israel Deaconess Medical Center as its new president and chief executive officer. In his position at HMS, he was responsible for administrative, budgetary, and facility management as well as government and community relations. He was also involved in coordinating collaborative ventures between HMS and its affiliates. ■

## High-Tech Teaching

**T**HE HMS CENTER FOR EDUCATIONAL Technology has opened its doors to faculty seeking ways to incorporate new technologies into their teaching. The first of its kind in the country, the center offers a full range of digital services and equipment, educational technology expertise, and technical support staff. It also administers a grant program for new curriculum initiatives.

"We at HMS are now well positioned to take a national leadership role in the

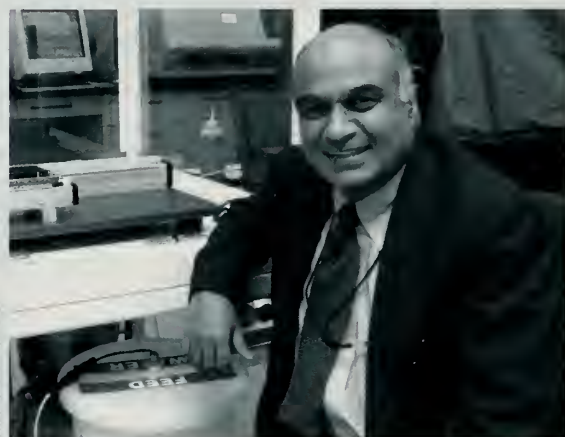
use of information technology to further medical education," says John Halamka, associate dean for educational technology. "When you combine the ubiquity of the Web with the rise of wireless and portable technology, you have the capacity to make all of our educational resources available anywhere, anytime."

Major features of the center include digital imaging services, such as video streaming, radiographic scanning, and digital microscopy. ■

### TECHNOLOGIES FOR TEACHING

- Video Streaming
- Radiographic Scanning
- Digital Microscopy

## IT'S ALL IN THE GENES



**INGENUITY AT WORK:** Raju Kucherlapati, the Paul C. Cabot Professor of Genetics at HMS, is scientific director of the Harvard-Partners Center for Genetics and Genomics.

The Harvard-Partners Center for Genetics and Genomics has opened a new genotyping facility. This core laboratory provides flexible, high-quality, high-throughput SNP genotyping to HMS, the Harvard School of Public Health, and hospitals in the Partners HealthCare network. Raju Kucherlapati, the Paul C. Cabot Professor of Genetics at HMS, is scientific director of the center. ■



**BUILDING BRIDGES:**  
Joan Reede's Office for  
Diversity and Community  
Partnership will guide  
diversity efforts at Har-  
vard Medical School.



## Leading the Charge

**J**OAN REEDE, FORMER ASSOCIATE dean for faculty development and diversity, has been named the first dean for diversity and community partnership at HMS. Under her leadership, the new Office for Diversity and Community Partnership will promote increased recruitment, retention, and advancement of underrepresented minority faculty at HMS, oversee all diversity activities involving HMS faculty, trainees, students, and staff, and coordinate the School's many interactions with community groups.

In appointing Reede, HMS Dean Joseph Martin noted that "Joan possesses strong leadership, networking, and consensus-building skills. Her success in developing new and exciting programs to enhance diversity efforts throughout the HMS community has been outstanding."

In the 2000-2001 academic year, HMS programs designed to foster an interest in science among minority students

served 452 participants, ranging from kindergartners to high school students. The Visiting Clerkship Program, which aims to increase minority medical students' awareness of opportunities in academic medicine, had nearly 500 participants. Research funding awards have been made to minority faculty members through the Bridge Award Program. And the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy has graduated 23 fellows since it began in 1996.

"In seeking excellence in education, research, and clinical care," Reede says, "there is a clear need to recognize and incorporate the talents, skills, and knowledge of diverse individuals and to understand that Harvard Medical School, as part of a larger community, must work collaboratively to address issues of health disparity, cultural competence, workforce diversity and, ultimately, quality health care." ■



## PORTOFINO, ITALY

A three-bedroom apartment with a spectacular view of the Mediterranean Sea is now available for rental mid-June to mid-September 2002. The apartment is located in a historic, sea-front building in the heart of the elegant resort town of Santa Margherita Ligure (in the Portofino area near Genoa). The town offers water sports, gourmet dining, upscale shopping, and hiking on scenic Portofino mountain. Daily excursions from Santa Margherita to Cinque Terre and other beautiful locations can also be arranged. Another apartment is available for rent in Treviso, near Venice.

For more information, write to:  
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# PRESIDENT'S REPORT

**I**T IS NOT CLEAR WHO READS THE President's Report—other than the president—in each issue of the *Bulletin*. Even the president will sometimes read the column and say, "I don't remember writing any of this." Sometimes past presidents read the current president's message and say, "I wonder who wrote *that*." Or presidents elect read the message and say, "Well, I'm not going to write anything like that." This is in contrast with the articles of the *Bulletin*, which are widely read and about which we often say, "I wish I had written something like that."

described the methodology in the paper, or in the appendix—I forget which.

This report is, in fact, about email and the Alumni Association. About 55 percent of HMS alumni are now networked to the Alumni Association office. Through the remarkable efforts of Nora Nercessian, the assistant dean for alumni affairs and special projects; John Halamka, the HMS associate dean for educational technology; and immediate past President Charlie Hatem '66—and with the support of Dan Federman and Dean Joe Martin—the Alumni Association is now able and ready to survey both the body politic and target popula-

Twice this calendar year, you will receive brief email surveys on topics important to the School, particularly education.

I recently wrote a medical journal article entitled "The Summer Solstice Has Been Rescheduled to August 21." I am mentioning this article just to test whether you are actually reading this message. If we get email from you at the Alumni Association office about the generally bad timing of the solstice each summer, I will tell the two presidents-elect, the past president, and Dan Federman '53 that these presidential messages are being read.

Some of you probably think that the solstice is not a big medical issue. Well, if we didn't have the summer solstice, the days would just get longer and longer—or, in the Southern Hemisphere, shorter and shorter—and scientists at a major midwestern university might think that the pituitary-adrenal axis would be doomed. Hence, my concern. So we need the solstice, but rescheduling it for late August from June 21 gives us a lot more daylight during summer vacation, and many scientists see this as a plus. Just how to do this is not a big deal and I have

tions of alumni. The system was test-marketed last year and it works. I recently contacted five other medical schools and found that none of their alumni offices had the capability of reaching alumni electronically.

Twice this calendar year, you will receive brief email surveys on topics important to the School, particularly its educational missions. Through this email mechanism you will be able to help shape the agenda and deliberations of the Alumni Council and to present your views to Dean Martin. In the next year, the Council will also seek from you the measures you personally use to place value on what you do professionally in this era of health care system tumult. We will also use the Web to provide updates on plans for alumni activities, particularly those that take place at the time of medical school graduation. We look forward to hearing from you regularly. ■

*Paul J. Davis '63 is senior associate dean for clinical research at Albany Medical College.*



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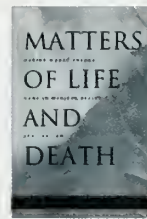
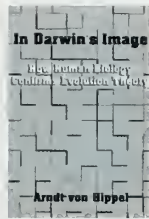
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## Idaho Mountain Wildflowers

*A Photographic Compendium*, by A. Scott Earle '53 (Larkspur Books, 2001)

A lifelong love of nature, mountains, and photography is reflected in Earle's collection of more than 300 color images of mountain wildflowers. The flowers illustrated are typical of flora found in Central Idaho; all grow at altitudes of 6,000 feet or higher.

## In Darwin's Image

*How Human Biology Confirms Evolution Theory*, by Arndt von Hippel '57 (1stBooks, 2001)

Life's origin provides the point of departure for this book, which reviews the layered progression from bacterium to nucleated cell to multicellular organism and examines the efficiencies gained through cell specialization. The author's overview of human biology concludes with evolutionary insights into human sexuality and embryonic development.

## Out of Its Mind

*Psychiatry in Crisis—A Call for Reform*, by J. Allan Hobson '59 and Jonathan A. Leonard (Perseus Publishing, 2001)

This book considers what's wrong with the field of psychiatry today, how it got that way, and how to fix it. Hobson and Leonard demonstrate that psychiatry now suffers from a lack of public confidence and a "split-personality" disorder in which humanistic therapy is often

poorly coordinated with, or even divorced from, biomedicine. They propose the development of a balanced approach to treatment—neurodynamics—that bridges the worlds of biomedicine, therapy, and neuroscience.

## Borderline Personality Disorder

*A Clinical Guide*, by John G. Gunderson '67 (American Psychiatric Publishing, 2001)

The author, whose research helped establish borderline personality disorder as a psychiatric condition, evaluates the strengths and weaknesses of various diagnostic and treatment perspectives. He addresses his own approach, psychodynamic therapy, as well as "dialectical" behavioral therapy, group and family therapy, and pharmacotherapy. Gunderson also offers insights and case examples from his clinical experience, and takes the reader through the phases of the typical course of treatment.

## Matters of Life and Death

*Making Moral Theory Work in Medical Ethics and the Law*, by David Orentlicher '81 (Princeton University Press, 2001)

The author draws upon his experience in both medicine and law to address the translation of moral principle into practice, using controversial life-and-death issues as case studies. He evaluates three models, including physician-assisted suicide; the debate over forcing pregnant women to accept treatments to save their fetuses; and the denial of

life-sustaining treatment on grounds of medical futility. Orentlicher argues that important debates in bioethics can be better understood when one takes into account moral concerns that are often overlooked.

## Landscape with Human Figure

by Rafael Campo '92 (Duke University Press, 2002)

Campo's fourth collection includes poems that address a range of human experiences, including the doctor/patient relationship, the ravages of AIDS, healing and suffering, identity, sexuality, and love. A teacher and practitioner of general internal medicine as well as an award-winning poet, Campo vividly demonstrates the healing power of words.

## This Side of Doctoring

*Reflections from Women in Medicine*, Eliza Lo Chin '93, editor (Sage Publications, 2001)

This collection of stories, poems, and essays, written by female physicians over the past 150 years, offers a fresh perspective on doctoring. Organized into categories such as "Life in the Trenches: Internship and Residency," "Mothering and Doctoring," and "Making Choices," the anthology explores the struggles and triumphs of women in medicine. Chin also provides a historical overview of the obstacles faced by nineteenth-century women physicians.

## Spoiling for a Fight: Fruit Fly Model Helps Research on Aggression

**T**HE FIGHT BEGAN AS THESE fights often do. The two male rookies circled each other warily. Making the first move, the yellow-clad youth approached and charged his competitor. The one wearing the white spot bristled in defense, seized the offensive, and lunged in retaliation. Wings flared. White soon chased off yellow, ending the fight and establishing dominance in mere seconds.

Without the catchy superlatives or clever nicknames usually associated with the sport of boxing, this fight club for fruit flies has been going on for more than a year in the laboratory of Edward Kravitz, the George Packer Berry Professor of Neurobiology at

HMS. The mild-mannered Kravitz has promoted more fights than Don King. For 20 years, pair after pair of young lobsters have challenged, darted, and wrestled their way to dominance or defeat. Then last spring, Kravitz's research team began staging matches involving the common laboratory fruit fly, *Drosophila melanogaster*.

The researchers are collecting baseline data to calculate statistically what constitutes a "normal" fight. Based on preliminary analysis, the fights and subsequent behaviors seem to follow rules set by a combination of genetics and fight outcomes. Kravitz wants to use the fighting fruit fly model system to explore the neurobiology of aggression.

In this case, normal does not mean natural chance encounters. The fights take place between pairs of three-day-old males, raised in isolation and then trapped together in a small, temperature-controlled, clear plastic and glass chamber. There a headless, pregnant fruit fly perches on a bottle cap-sized food cup. (Females with heads intact tend to fly away from the fight.) The female lures the males to the cup, where the flies instinctively wage a turf battle. On one side of the chamber is the close-up lens of a digital camera set on a tripod.

So far, the researchers have videotaped 75 fights between flies involving 2,000 rounds. Fights can be decided after encounters as short as a few seconds or as long as 1.5 minutes. The average time is 11 seconds. The first male to reach the food surface usually picks the fight.

The researchers score rounds at three intensity levels. High-level encounters last longer (26 seconds) than mid- and low-level rounds (12 and 6 seconds, respectively). After a high-intensity round knocks the loser off the fruit cup, the defeated fly takes about twice as long to engage in another encounter (52 seconds) as it takes after a low-intensity encounter (28 seconds). The difference suggests a long-term component to the fighting behavior.

This long-term component may reflect changes in gene expression in the brain. Two decades of researching the conveniently large neurons in the lobster has helped Kravitz define some of the neurotransmitters important in aggressive behavior, and to identify circuitry important in the winner and loser roles adopted by the lobsters.

"We don't know how, but the business of being beaten clearly has a dramatic effect on the life of a lobster," Kravitz says. "After a fight, one becomes dominant, the other subordinate. The dominant animal advances all the time, and the subordinate runs away and won't fight. After a half hour of fighting



**PUT UP YOUR DUKES:** The research team of Professor Ed Kravitz and undergraduates Selby Chen, Ann Lee, and Nina Bowens (not pictured) has scored dozens of fights between fruit flies, hoping to gain more insight into genes underlying aggression.



in lobsters, animals can remember for up to a week who is a winner and who is a loser without having any fights in between and after being separated from each other."

Fruit flies offer Kravitz and his colleagues an opportunity to use new genetic research tools to explore changes in gene expression related to changes in social experience and to identify pathways important in animals' aggressive behavior.

"Aggression is a serious problem in society, but even after studies of lots of animal models for many years, we don't know a lot about the biological basis of aggression," Kravitz says. "We know that some chemicals like serotonin are very important, but beyond that, much remains to be discovered."

If nothing else, it is a field of study that will never be dull. ■

*Carol Cruzan Morton is a science writer for Focus.*

#### FLIES OFF THE HANDLE



Rarely seen, fruit-fly fights can reach a high level of aggression when the animals box (left), wrestle, and tussle. Mid-level aggressive moves are more common (below left), such as the close chase by the winning fly on the right and the defensive wing threat by the loser on the left. Most fights are decided by low-level aggressive moves, such as a wings-up display (below right), charging, or a limb lifted to the side.



## ON THE SCENT

**T**he brain takes only a split second to perceive and respond to a smell, whether it be the aroma of roasting turkey or the sour odor of leftovers gone bad. But it has taken a long time for researchers to meticulously trace sensory information from the nose to the brain, which ultimately perceives thousands of different odors. Now, researchers have shown how information from nasal odor receptors is organized in the brain's olfactory cortex.

The olfactory cortex has a sensory map that is virtually identical in different individuals, report Howard Hughes investigator Linda Buck, an HMS professor of neurobiology; postdoctoral fellow Zhi-huo Zou; and their colleagues in the November 8 issue of *Nature*. The nose has about a thousand different types of odor receptor. In the study, information from each of two types of receptor reached distinct clusters of neurons in all five olfactory cortical regions except for the amygdala. The patterns were consistent among ten knock-in mice for each of the two individual receptors studied.

"This was in the mouse, but humans use the same strategies to detect and discriminate odors," Buck says. "The invariant

arrangement may explain in part why people have similar sensations of particular odor chemicals. Most people agree that skunks do not smell good, but roses do."

Finding odor patterns in the brain may be enough of a surprise for some people, but the results also suggest a reorganization and possible integration of information from different odor receptors for further distribution to higher processing levels, where they may trigger different odor perceptions as well as instinctive and emotional responses. And inputs from the same receptors may be processed at the same time by functionally distinct areas of the olfactory cortex before the information is forwarded in the brain.

"We still don't know exactly how different chemical structures are ultimately translated into perceived odors," Buck says, "but we do know now that sensory information undergoes a dramatic transformation in the olfactory cortex, and that there is a highly organized pattern of sensory inputs—order that some people thought did not exist."

—Carol Cruzan Morton

## All in Good Time: Setting the Circadian Clock

**A** RECENT STUDY REVEALS ONE OF the first glimpses of how the brain's circadian clock—a tiny cluster of neurons behind the eyes—sends out signals that control the body's daily rhythms. The newly discovered pathway opens a long closed door in the field of circadian clock research and could ultimately lead to novel treatments for sleep disorders and other circadian disturbances.

"If you could figure out the factors that promote wakefulness and sleep, that could in principle be turned into better drugs for particular sleep disorders," says Charles Weitz, HMS professor of neurobiology. His team's findings appear in the December 21 issue of *Science*.

Circadian researchers have been remarkably successful in the past few years at identifying the molecular machinery that makes the clock cells of the suprachiasmatic nucleus (SCN) tick on a nearly 24-hour basis. But they were stymied when it came to figuring out how that machinery actually drives daily rhythms such as the rise and fall of body temperature and the sleep-wake cycle. They suspected that the rhythmic patterns were achieved by a turning on and off of behaviors and that this switching was produced by factors for activation and inhibition. They even had an idea where the factors might reside in the brain, but no one had yet found any.

### Stopping the Clock

Weitz, Achim Kramer, and colleagues have identified the first of what could be several inhibitory factors controlling the circadian rhythm of locomotion in a mammal, in this case, the hamster. (Circadian locomotor patterns, which are characterized by periods of spontaneous movement occurring at the same time each day, exist in humans but are highly influenced by external factors.) In addition, they have found that the factor, TGF- $\alpha$ , works through a middleman, the EGF receptor. Both proteins

appear to be highly expressed in exactly the spots that had been predicted—TGF- $\alpha$  in the SCN and the EGF receptor in the nearby hypothalamus.

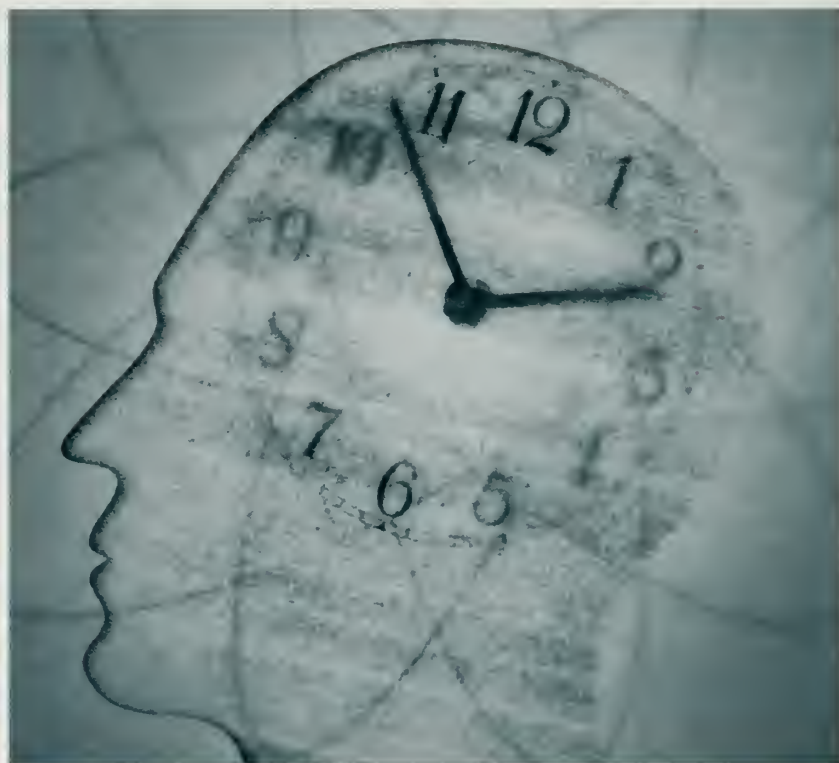
Yet there are several unexpected aspects of the discovery. To begin, it appears that the molecular duo regulates not just daily physical activity patterns but also the alternating pattern of wakefulness and sleep. More surprising, perhaps, is the discovery that the EGF receptor middleman appears to receive information in the form of TGF- $\alpha$  not just from the clock but also from the eyes. This is exciting because circadian rhythms, though controlled by the clock, could be influenced by the outside world and, specifically, by light transmitted through the retina.

"In the real world, it is both effects—the clock effect and some light effect—that are really sculpting behavior," Weitz says. "No one had explicitly raised the possibility

that the signal from the retina and the SCN might involve the same ligand or at least a ligand for the same receptor."

### In the Eye of the Beholder

To find the missing factors, Weitz, Kramer (who was then an HMS research fellow in neurobiology), and their colleagues introduced SCN-produced proteins into the brains of hamsters for a period of three weeks to see which might inhibit the normal locomotor activity pattern. Normally, the nocturnal hamsters are very predictable—jumping on a running wheel at almost exactly the same time each evening and for the same duration. The hamsters receiving TGF- $\alpha$ , however, refrained from this habit for the three-week experimental period. At the end of this time, they jumped right back on the wheel. But it was still not certain whether their laxi-





## Pain and Pleasure Activate the Same Brain Structures

ty during the experiment had been due to some disruption in their circadian rhythm or to a more basic motor impairment.

Once the researchers confirmed that TGF- $\alpha$  was working through the EGF receptor and that the pair was located in the expected regions, they conducted a series of physiological tests on the TGF- $\alpha$  animals to answer this question. The tests showed that the animals moved just fine around their cages, though not on the wheel, suggesting their motor systems were intact. Yet their sleep patterns were strange. "It appeared the high concentration of TGF- $\alpha$  was blocking some circadian input and removing them from the sleep-wake cycle," Weitz says.

Since the animals had been experimentally manipulated, Weitz and his colleagues still wanted to know if TGF- $\alpha$  and the EGF receptor were regulating circadian patterns in the real world. Fortunately, nature had produced a convenient experiment: a strain of mice with a defective version of the EGF receptor. "No one had ever looked at their locomotor patterns," Weitz says. It turned out that the mice—deprived of the full inhibitory activity of the receptor—were much more active than normal mice.

Intriguingly, the disparity with normal mice was more marked in animals living under a normal light-dark regimen than those living in total darkness. Normal mice, when exposed to light, stop moving, perhaps as an adaptive response, which can result in less activity. The researchers found that this effect was impaired in the EGF receptor-deficient mice raised under light-dark conditions, which exaggerated their difference with normal mice raised similarly.

Thinking that the EGF receptor might be receiving signals from the retina as well as the clock, the researchers looked for TGF- $\alpha$  in the retina. They found it, along with another receptor-stimulating protein, EGF. "So it all fits together," Weitz says. ■

Misia Landau is senior science writer for Focus.

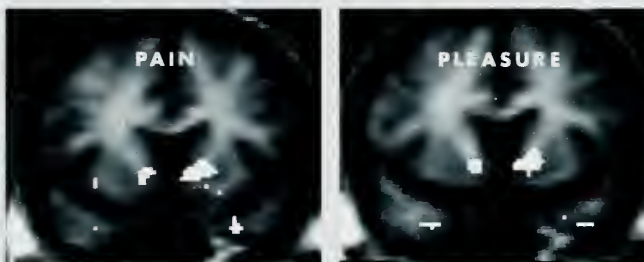
**T**he notion of a fine line between pain and pleasure is finding support in biology, according to a new report by Massachusetts General Hospital researchers.

David Barsak and his colleagues have discovered that circuits in the brain that are responsible for reacting to pleasurable experiences also respond to painful ones.

Even more surprising, some of the circuits associated with reward appear to react more quickly to hurtful stimuli than do the sensory areas of the brain traditionally associated with pain. The findings appear in the December 6 issue of *Neuron*.

The idea for the study arose in part out of Barsak's experience as a clinician. "Over 15 years of seeing patients with pain it became obvious that we do not have good methods of assessing chronic pain," says Barsak, HMS associate professor of radiology. "And we do not have good methods for treating it."

To get a better understanding of the actual neuronal circuits involved in pain, Barsak—along with Lina Becerra, HMS assistant professor of radiology, and their colleagues—attached thermodes,



**GOOD GRIEF:** The same areas of the brain (highlighted above) respond to both painful and pleasurable stimuli.

which deliver either warm or painfully hot temperatures for 25 seconds, to the hands of eight male volunteers. They imaged the brains of each subject as he was exposed to the stimuli.

The painful hot temperatures activated not only the classic pain circuitry but also structures previously identified as being activated in response to emotionally rewarding stimuli, such as cocaine, food, and money. The emotional circuits become most active immediately after heat exposure, while the sensory areas showed their greatest burst of activity later in the 25-second interval.

"It's the first time we have seen something aversive activating these reward structures," Becerra says. One explanation is that these areas are simply responding to salient stimuli.

Gaining a better grasp on the pain circuitry in the brain could lead to new treatments. "Prior to our study, most data could define the sensory response," Becerra says. "Understanding this newly identified emotional component may be a key to developing new approaches to helping chronic pain patients, who are at increased risk for anxiety, depression, and suicide."

—Misia Landau

# SILENT

What happens when physicians don't care for the patients they're caring for?

# TREATMENT

by RAFAEL CAMPO ■ When I arrive, she is sitting beside her hospital bed, in one of those tall, vinyl-upholstered chairs that looks like it might recline comfortably, but actually doesn't. An adjustable tray bearing what might be called lunch is angled before her, as though she has pushed it away; I can see through the translucent plastic covers on the plates that she hasn't touched any of it, not the perfect scoop of mashed potatoes, not the gray-brown square of pot roast, not the pyramid of tiny wrinkled peas. Futuristically geometric food, suitable to the sterile confines of the wards, surroundings as white





# I SUPPOSE

I should say something to me. I had never noticed

and airless as what we imagine a spaceship's interior would be like. Faint humming from nowhere and everywhere, and sporadic beeps.

"Oh, it's you," she says, and I return from the future. She is wrapped in the standard-issue, blue-checked hospital gown. She looks terribly gaunt. I remember why I've come.

I am trying to understand why I have never liked Miss Twomey.\* I have been her doctor for more than six years. During that time, surely, the cancers, one in her colon and another in her breast, slowly developed and grew, and maybe even metastasized. I suppose I should admit that when she came to see me last week, dressed in her usual prim attire—the same beige cable-knit sweater loosely buttoned over the same cream rayon blouse, and the same calf-length navy blue pleated skirt—I had felt something akin to vindication as she complained, matter-of-factly, that she was feeling listless. Her cheap perfume, as on previous visits, only partially obscured the sour odor of old sweat from beneath her arms.

I knew as soon as she had walked in my office that day that she was out of sorts. Though her clothes were neat as ever, I noticed that her white hair was not as carefully groomed as it usually was. Her thin lips were a faint purple color, and she swooned slightly, steadying herself on my arm when she rose for me to check her blood pressure. I don't think she had ever spontaneously touched me before. When I felt through the sleeve of my shirt how cold her hand was on the back of my arm, I was sure she must be anemic. At her advanced age—she would be 84 in December, just a few weeks away—I guessed even then that it would turn out to be a cancer of some sort. What surprised me was the feeling I had that she deserved it.

Just as she had that day in my office, she sits with her hands folded in her lap, looking impassively ahead so that I am kept in the periphery of her field of vision. "They tell me it's bad," she says. A long pause, before she adds, "The cancer." By "they," she is referring to the hospitalist, I think, and the general surgeon, who have been managing her care since she was admitted, the day after our last visit. She had turned out to be anemic—hematocrit of 20, to be precise, with a marked microcytosis. The colonoscopy I arranged urgent-

ly, with the help of the clinic social worker, who assisted her with the last-minute transportation, showed a six-centimeter adenocarcinoma in the ascending colon. I can't imagine the indignity of the test for her, she who was too proper to allow me to examine anything more than her blood pressure on her biannual visits; even harder to imagine is the medical student examining her breasts upon her admission to the hospital, and finding the mass the size of a baseball. "I should have let you do the mammogram," she says now, resigned if anything, and not particularly regretful. Her hand clutches absently at the opening of her gown below her neck.

I suppose I should say something comforting, but the spiky whiskers on her chin stop me. I had





comforting, but the spiky whiskers on her chin stop them before; they glisten a little in the sunlight.

never noticed them before; they glisten a little in the sunlight the window lets in. Though I've been in these hospital rooms hundreds of times before, today the windows seem so large, as if to encourage breathing, or even flight. Miss Twomey's overlooks the women's college's athletic fields across Brookline Avenue, vast green squares, almost pastoral. I notice their manicured appearance reflected in her wide-rimmed glasses, their milky white plastic frames, inexpensive and unfashionable, like the last pair my grandmother wore. Life and order juxtaposed on dissolution and death, I think rather heartlessly; not even the unusual warmth of the late autumn day outside, or the fleeting memory of my own grandmother, is enough to inspire my pity.

It isn't that Miss Twomey routinely refused almost all of the health maintenance interventions I would offer her; it isn't her South Boston Irish accent, either, that I find so distasteful, or even her body odor. And yet I can't put my finger on it. I am not used to problems with empathy. Besides my work as a physician, I am also a poet, and when I give readings of my work, I like to talk about empathy. I like to share one story in particular about when I was a young resident, and one of my attendings wrote an evaluation that criticized me for identifying too strongly with my patients. Usually, the audience gasps and groans a little when they hear this story; sometimes, tears come again to my eyes when I tell it, because after all these years the cruelty of those words, scrawled hastily on a sheet of yellow lined paper stuffed in a folder with my name on it, still stings.

I am no longer a thin-skinned trainee, though, and I have no attending telling me to be tougher, so why can't I empathize with Miss Twomey? Why can't I reach out, and take her hand in mine? Suddenly, my mind is flooded with all the obstacles to empathy that I am so fond of reciting, familiarly framed problems for the medical students and residents: the burgeoning technologies of medical science, which place ever more machines between doctors and patients; the constraints of managed care, which puts the interests of the afflicted at odds with those of their caregivers in complex ways; the challenges of an increasingly multicultural society, through which each comes to see the other as incomprehensibly alien.

True, Miss Twomey had been diagnosed with the help of expensive machines, but none interposed themselves at the moment; even the device that controlled her IV fluid rate was turned off, its fat gelatinous bag of saline suspended unconnected to anything, as if sulking in the corner of the room. True, she had a type of insurance that failed to reimburse fully the hospital's charges for the care she required, but no utilization review nurse was knocking to tell us she must be discharged today. Even the fact of our disparate points of origin seemed irrelevant; if anything, as children of immigrant parents, albeit from different generations and different island cultures, we likely had more in common than most doctors and their patients. Standing



# WHILE IT'S

probably true that  
I've always believed

here in her doorway, feeling intensely how much I don't want to sit on her bed and stay to chat, this litany sounds canned, glib.

One common response to my lectures, usually posed by a silver-haired Marcus Welby-gone-wrong type in the back of the auditorium, is that one can't teach empathy; it's either there somewhere inside a person, he says gruffly, or it's not. I love this objection, because I get to retort that while it's probably true that empathy can't be grafted onto the unwilling soul, I've always believed that at the very least it can be modeled, and through such modeling, even the most rudimentary or stunted capacity for empathy can be nurtured. Bring poems about illness on rounds, I say, embrace a patient after the physical examination is concluded; remain open to sharing a spontaneous joke. Make a point of asking for any questions, or greeting family members who might be present at the bedside.

If his beeper hasn't gone off calling him away to a less philosophical situation—I know he must have a very sick crew of inpatients, and I empathize with him, imagining his frustration in treating the GI bleeder with alcohol withdrawal seizures in the ICU, or the demented elder who isn't safe to return home alone but who is repeatedly declined placement in long-term care facilities, or any of countless other commonplace and irremediable scenarios—my interlocutor usually looks exasperated by my answer, as if one more unreasonable demand has just been made of him.

I know I am often dismissed as a daydreamer, an impractical poet, so I often try to buttress my arguments with references to the likes of the literary theorist Susan Sontag or the social anthropologist David Morris; sometimes, I cite political activist authors like Adrienne Rich or the late Audre Lorde. I give examples of how negative metaphors for illness constructed by our culture can color our thinking about our patients, when we talk of blasting tumors with radiation or when we imagine the agony of withdrawal as a kind of punishment to the narcotics addict; I point out how the kind of language patients might use to describe their own experiences of illness, more positive and affirming, might fuel a mind-body interaction within them that has

healing potential. By now, the room is beginning to empty of audience, and the drug rep starts to pack up any left-over sandwiches; they are all returning to the innumerable stories they are helping to construct, barely awakened to their role in those dramas, happier to ignore the messy cultural fascinations and distortions that—so much more than x-ray interpretations or biopsy results—define the experience of illness, intent only that the onerous work of the hospital continue.

Miss Twomey gazes toward the windows; I realize that my ruminations have been prolonging our uncomfortable silence. Then she says it, as though she were addressing one of the large oaks that blaze orange at the far end of the fields. "I'm not afraid to die, like you think I am." Her words are punctuated by the distant shouts and laughs of the Simmons field hockey team, which has begun to spill like some of life's happy disorder onto the perfect grass; afternoon practice, the thrill and release of being free of the classroom and the library, free of concepts and chalkdust and theories, in the realm of the body, the physical, the pleasure of adrenaline and hard breathing. By the time the young women begin their scrimmage, Miss Twomey is quietly sobbing.

Several weeks later, I find myself writing again, and I am writing about Miss Twomey. Her tears seem more than a vivid detail that describes my visit with her that day; now, I understand them as a form of language itself, perhaps the only language that can accommodate a definition of empathy. The poem I write, and now this essay, can only approximate the feeling that joined us at that moment; indeed, one of the pitfalls of empathy is the kind of paradoxical hubris it can breed, tempting us to believe that we can truly know and thus explicate the experience of another person's suffering. Yet such is our utterly and fundamentally human limitation, each of us



empathy can't be grafted onto the unwilling soul,  
that at the very least it can be modeled.



born into families and communities full of their mysteries and contradictions, their pleasures and their pain, human gatherings that we yearn to join; equally human, it seems, is our impulse to transcend that limitation, to attempt to make sense of that innate need for communion.

For whatever reason I could not embrace Mary Twomey that awful day—shame or guilt, revulsion or rage—to tell the story of us, together amid those tears, the day declining into a night as sorely purple-red and inflamed as a bruise, an injury I

know I will someday face myself, is a biological drive, a process of living. Here, then, is the reason I am hopeful; here, in this brief narrative I create, this tether between two people, is the meaning we all seek in life. ■

*Rafael Campo '92 practices medicine at Beth Israel Deaconess Medical Center. He is the author of a collection of essays, *The Desire to Heal*, and four books of poetry: *The Other Man Was Me*; *What the Body Told*; *Diva*; and *Landscape with Human Figure*.*



# RAYMO

Some patients inspire doctors to swear oaths less than Hippocratic



# EVERYBODY

# HATES AND

*A gentlemanly mentor once said: In the beginning, you must find something to admire in a patient. The relationship does not always end in admiration, he explained. But it must begin that way. This is our oath of good care and intention, taken fervently, but not always possible. ■ The patient had arrived*

by ELISSA ELY

# IN A VOICE

between a sandblaster  
list the details of the

months ago with 18 years of diagnoses: impulse control disorder, attention deficit disorder, obsessive compulsive disorder, narcissistic disorder, and—from one annoyed diagnostician—inadequate personality. He had a knitting basket of diagnoses, which helped to understand him—you could plunge your hand in anywhere and pull out a color—but not a single admirable quality that helped to excuse him.

It was not only the absence of the likable, the brave, the inspiring. It was not as simple as ordinariness, or mere indistinguishability. He was distinguishable. With relentless self-interest, he made himself impossible to forget and impossible to pity. He followed patients and staff from room to room, cornered housekeepers mopping floors and maintenance men hovering with wrenches. In a voice between a sandblaster and a just-unclogged drain, he would list and list and list the details of the car he did not have (Mazda Miata), the house he could not own (in Hawaii or Disneyland), the girlfriends he had not found (blonde). There was never reciprocity in the conversation, no inquiry outward or capacity to see beyond his yearnings. A therapist could grasp these yearnings as poignant, even endearing. But they were not the greater part of him.

The greater part of him was kinetic and unpredictable, an electric toy after someone has poured water on the wires. He was publicly impulsive and immature, holding a knife to his chest in traffic. He was filled with violent and vocal sexual fantasies. He attacked other patients deliberately. He refused to shower. The cats behind the food building, advanced diagnosticians, saw him coming and spread their fur.

It was Monday. It had rained all weekend and a lunar eclipse was on the horizon. The mute woman who kept the bulletin board had written, in her usual capital letters: THIS IS HOSTAGISM. The week before, her message had been: ARISTOTLE AHOY.

He sat next to me in the day hall during the morning meeting. A large, very simple woman limped by. There was a nasty and uncreative exchange. "You're always whining, you fat pig!" "Look in the mirror when you say that!" "Look

yourself!" Then it exploded. I saw it in slow magnification; my patient hurtling past me—actually over me—onto her. Spit and nails flew. They were split apart by the nurses (always, the nurses), and sent to separate rooms. My patient wept for himself. He could never remember who the victim was.

The meeting continued. A nurse asked whether anyone had ideas about how to decrease the assaults on the unit. "Easy," said someone in a bowler hat. "Kill the one who always starts it."

There it was. Everyone knew whom he meant. The more socialized among us weren't free to think it out loud—education forbade us. But my patient had united both sides of the floor. The man had made a profession of loathsomeness. It may have had to do with a broken brain or early history, maternal deprivation, or a lack of multivitamins. Wherever it came from, his blood was bad.

A certain kind of therapist, someone hard at work on a thoughtful book, might have talked about the importance of understanding this patient's need to make himself detestable. He would have reminded us that we endure difficult patients by knowing more about them than they know themselves. He would have wondered gently, observed the patient with interest, attended with diligence. He might have pointed out some poignant detail of self to evoke sympathy. He would have cautioned the rest of us not to let our emotions interfere with our duty. Then he would have glanced at his watch, realized the time, nodded his head courteously, and left the locked unit. It is one



and a just-unclogged drain, he would list and list and  
ear he did not have, the house he could not own.



thing to grasp a patient theoretically. It is another to endure him in real time.

I imagined the fight again—it could have been any of the daily fights he found himself in, but this last one was closest to memory and closest literally to me. The large, simple woman, who had few words and even fewer known thoughts, passed by. Insults flew. He hurled himself at her. But the staff did not come running. Instead, she drew up and hit back. She returned every punch. She was larger and stronger than he was. She spoke for all of us. No one stopped her.

My imaginings gave shameless and unattractive satisfaction. Everyone deserves treatment; we are not allowed to refuse it. But in the world of humans tending other humans, there are some patients who make us want to deliver personal justice. Personal justice is against the oath of good care and intention, against all training, and of course, against the law. It is unprofessional and unphysicianly. But in our worst moments, we can dream about it. ■

*Elissa Ely '88, a lecturer in psychiatry at HMS, is also a commentator for National Public Radio.*

# IRE FIGHT

Physicians can learn to respond effectively when patients lose

*Every field manages anger in its own way. In the law or professional wrestling, anger is generally treated as a valuable commodity. In medicine, it is almost always seen as unwelcome, signaling a disruptive or dangerous breach in the doctor/patient relationship. So instead of acknowledging the emotion, patients and doctors often collude in avoiding the issue—sometimes to the detriment of their working relationship.*





# ERS

their patience *by* JOHN G. GUNDERSON

# MEDICAL

crises can often transform anger, which temporarily

Doctors may face less anger than other professionals because patients usually have at least a superficial sense that they're not supposed to be angry with their doctors. Often patients look up to the physician as someone whose motives are benign, from whom they can expect to receive relief from their suffering. Because we doctors share the patient's image of ourselves as

beneficent authorities, we are often poorly prepared for encounters in which patients direct anger at us. Many of us feel that we're on the front lines doing good things for people, and we expect people to respect, if not laud, our motives. So, when our good intentions generate anger, we sometimes feel misunderstood, unappreciated, hurt, or even angry ourselves. Since

## Explosion Control

*Tips for handling your patients' anger*

- 1. Notice when a patient seems angry, then bring it up. This direct approach may uncover important information.**
- 2. When a patient appears to be angry or is behaving angrily, help him or her acknowledge and verbalize that anger.**
- 3. Validate the reasons for a patient's anger. This helps reduce feelings of being disrespected, ignored, and helpless.**
- 4. When you are scared, consider saying so. Efforts to assert control can make the situation worse.**
- 5. When a patient angers you, wait until you have had a chance to cool down and compose your thoughts before reacting.**



# feelings of fear or helplessness into feelings of allows people to think they're taking charge.

these feelings are discordant with our professional self-image, our reflex is to avoid them and the circumstances that prompt them.

Patients may find many occasions to feel angry with their doctors. The physician's words or actions may have left the patient feeling bullied, neglected, or unheeded—perhaps because the physician has indeed been oblivious to the

patient's concerns, or because the patient is hypersensitive in ways that the doctor has little reason to suspect. Medical crises can often transform feelings of fear or helplessness into feelings of anger, which temporarily allows people to think they're taking charge. This is true not just for patients; family members may displace dissatisfaction or rage at the patient onto the doctor.

Patients may manifest anger as impatience, rudeness, lateness, missed appointments, non-compliance, or uncooperativeness. Sometimes the patient's anger will be direct, which is easier to respond to than indirect anger. If things heat up, anger may lead to the physician being threatened with legal action—or even physical harm.

## Do Ask, Do Tell

Whatever the reason—the desire to adopt the moral high ground, or perhaps a discomfort with emotion—physicians often respond to a patient's anger with avoidance. This strategy is, unfortunately, the least productive. The best immunization against this potentially vicious cycle is curiosity. If your patient becomes angry, you'll handle yourself and the situation more comfortably and effectively if you become attentive and inquiring rather than injured. This may be easier said than done, but it's well worth the effort.

I often encounter anger in my work as a psychiatrist diagnosing and treating patients with borderline personality disorder. If a patient's anger arises because of insensitivity on my part, that dynamic is important to acknowledge and explore with the patient. Often the anger will occur because the patient is carrying around a lifelong grievance that is repeatedly bruised by situations that most people would find innocuous. Most people don't want to go through life being angry, so I tend to view this grievance as a kind of handicap that the unfortunate person carries through life.

The key here is that if you don't ask, you won't know. So perhaps the most important principle is to notice when a patient seems angry, then bring it up. This direct approach is often disarming and may uncover information that you have been missing. Consider an instance in



# HELPING patients realize that they their sense of potency or

which you enter the examination room and notice that your normally affable patient appears tight-lipped. Wanting to avoid upsetting the patient further, you proceed to do your best job, perhaps a little more meticulously and deliberately than usual. The patient leaves manifestly less happy than before.

Now let's rerun the tape. You come in and say, after you've noted the patient's demeanor, "I'm not sure, but you seem upset or frustrated." The patient now responds, "You know, you came in late this morning. I'm sorry to complain, but I'm supposed to be somewhere after this appointment, and I was worried that I wasn't going to be finished on time." Now you're dealing with accurate information, and you can go a long way toward correcting the problem. An easy apology—"I'm sorry, I do my best to be punctual, but sometimes..."—reestablishes an alliance and prepares you to be sensitive to this issue should it recur. I would add that doctors should not assume that habitual lateness is acceptable to their patients.

## All the Rage

You may not be the only one who gets better information if you point out to patients that they seem angry. Many people have difficulty recognizing or acknowledging their own anger. Such people are greatly handicapped because they can't use anger to protest on their own behalf. You are doing them a service if you can identify the feeling for them and help them to acknowledge it. (This is not, by the way, the same as urging people to express their anger indiscriminately.) Knowing one is angry and being able to say so are generally adaptive capabilities that we take for granted.

By recognizing that someone is angry, not only do you help sort out the facts of the situation, but you also take the first step toward resolving the anger. Validation is the key, for angry people don't feel the least bit better when their anger isn't taken seriously. You can acknowledge that someone may have a good reason for feeling angry without turning the situation into a judicial proceeding. You might say something like, "Wow. I didn't suspect that you would feel so

strongly about my unfortunate choice of words!" This is not an admission of harmful intentions; it simply recognizes the patient's discomfort and opens the way to talking through what happened. Insofar as you dismiss or minimize a person's anger, you will escalate it proportionately.

This principle holds true even when a patient becomes agitated or threatening. The instinct is often to threaten right back, saying, for example, "If you keep this up any longer, I'll have to call security." This may work if security has a rapid response time. Failing that, you are likely to be better served by an approach that seems counterintuitive but can often be more effective—a little like leaning downhill while skiing.

Threatening behavior can arise from a patient's effort to gain control of an overwhelming situation. A sense of being unseen, helpless, or persecuted usually underlies the behavior. Addressing these underlying feelings can go a long way toward defusing the situation. Validating the anger, even of someone threatening, can reduce that person's sense of being disrespected, ignored, and helpless.

The next step may be even less obvious, but it can be critical. If the person is scaring you, simply say, "You're scaring me." Helping patients realize that they are able to scare you is usually reassuring to their sense of potency or agency—exactly what they believe they have lost—and it opens up options for a dialogue about how to de-escalate the situation. It is generally safer—and more useful—to tell someone you're scared than to try to assert control.

## Clear and Present Danger

The most uncomfortable I have been with an angry patient was many years ago when I was interviewing an inmate at Bridgewater State Hospital, the Massachusetts correctional facility where potentially dangerous people charged with a crime receive psychiatric evaluations. The patient got agitated; I got scared. I didn't see any way to push the security button without lunging past him. Someone passing by happened to look in and, perceiving my state of anxiety, entered the room. This interruption did not upset the patient; he too was relieved, having felt trapped.



# are able to scare you is usually reassuring to agency—exactly what they believe they have lost.

Since then, I've been very quick to tell angry people that they're frightening me. It may be that I've just been lucky, but I have yet to see a patient who was not reassured by this message.

In a threatening situation, of course, a patient needs some kind of containing or coercive action. The most dangerous state of affairs is one in which the balance of power is ambiguous. Unless it is possible to establish immediately and beyond doubt that the situation is secure, the preferred strategy remains acknowledgment of the mutual problem and then, perhaps, negotiation.

## In the Eye of the Storm

There is no avoiding some patients' anger if you cannot or will not do something they want you to do, or if you must propose that they do something against their wishes. When you come to this kind of impasse, the temptation may be to deliver an ultimatum: "If you won't come to your appointments on time, I won't continue treating you." Or, "If you don't stop using cocaine, I'll have to refer you elsewhere." Although such ultimatums may lead to the relief associated with the loss of a troublesome patient, it's worth thinking about whether the ultimatum is likely to help that patient. Rather than changing the behavior in question, the net effect may be that the patient leaves treatment or moves on to another clinician.

When you find your patient's behavior to be intolerable, or if the patient is asking you to do something that you cannot do, it is always more effective to phrase the problem in terms of your own inability to meet the patient's perceived needs or demands. For example: "You find it hard to keep your appointments and I can see how you would want me to be more accommodating, but I just don't have the flexibility to be available on that basis."

If a patient is doing something harmful, such as abusing cocaine, rather than threatening to refer the patient—as if the next doctor would accept such a referral—I would simply say, "I believe that my efforts are futile and, worse yet, the appearance of treatment perpetuates a sham that I fear may be harmful to you."

Another response might be: "I know you would like me to prescribe narcotics for you, and I certainly don't want you to be in pain, but I don't feel able to do that without jeopardizing my professional pride and reputation." A patient might ask for a letter claiming an injury that you cannot diagnose. Here you might say, "I would like to help, but I couldn't look myself in the mirror if I did that." In any of these cases, you are not implying that your patient is demanding, conniving, or criminal, but rather affirming your wish to help and stating that the action requested is not something you believe would help them or that you would feel right about doing.

Of course, you may reach a point at which unreasonable requests—or provocative behaviors—tempt you to respond with anger. In such situations, temporary avoidance is usually the better part of valor. Here it's best to wait a while, perhaps until the next time you meet, when the iron is, so to speak, cold. Then the opener might be something like, "You might have noticed that I got quite upset about what occurred. Had you expected me to react that way?" Then you might tell the patient that you got angry and clarify what it was that triggered your anger—whether you felt misunderstood, exploited, devalued, or ridiculed. Delay is valuable because it gives you a chance to think through your response, allowing you to phrase it clearly and in a way that is in the patient's best interest. Ignoring the anger can lead to a false sense in the working relationship and a recurrence or escalation of the request that is not in anyone's best interest.

It is unusual for any long term relationship to be free of angry feelings, even in the idealized and professionally constrained setting of a doctor's office. And it is common for people to believe that the anger should be neither felt nor expressed—especially toward those whose help they are seeking. The basic tools for dealing with anger are to recognize and validate the feeling, to express regret, and, if the interaction is scary, to say so. ■

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# TELL ME THE WORST, DOCTOR

Harvard-trained physicians recall some of their trickiest clinical encounters



PHOTO: MICHAEL GOODMAN FOR INTERNATIONAL

## STRONG MEDICINE

I WAS A THIRD-YEAR FAMILY PRACTICE RESIDENT, AND HE WAS A THUG, my senior in years, height, muscles, tattoos, and pockmarks. I was afraid he was going to beat me up.

His lovely pregnant wife and two beautiful children were my patients. I had delivered their younger daughter while he was in prison for drug possession and theft, and he had recently gotten out of prison again on the same charges. I had just finished seeing his wife for a prenatal visit and needed to confront him about his irresponsible behavior. I walked him down a hospital corridor and spoke softly about how wonderful his family was, how they needed him, and how he needed to take care of them. I was afraid he was going to beat me up. He didn't. He listened carefully,

nodded, and quietly thanked me. He was there for his son's birth a few months later and stayed out of prison. When I finished my residency, he gave me a present. He had used a wood router to carve my name into a two-by-four. That nameplate is displayed in my office as I write this, as it has been displayed in my various offices for the past 20 years.

—A family physician from Seattle, Washington





## The Power of Babble

A FRESH-FACED THIRD-YEAR STUDENT, I HAD BEEN ASSIGNED FLY ON THE WALL STATUS during a rotation in community medicine. The setting was small town America. My preceptor, Dr. S., was in solo general practice in his hometown, and he was caring for many patients who were aging along with him.

Fannie came in with her list. Dr. S. introduced me, sat down at his desk, and began listening to her litany. He took a few notes and then abruptly got up, excused himself to Fannie, and asked me to take over while he saw another patient. He returned a few

moments later and resumed his seat. Fannie didn't miss a beat but swiveled to face him and continued her relentless barrage. Suddenly, to my horror, Dr. S. began to slide slowly down in his chair, lower and lower, until he slipped off the chair completely and disappeared out of sight into the kneehole of his desk. Unfazed, Fannie followed him, leaning forward to maintain the same personal space between them, all the while moving resolutely from item to item on her list.

Finally, they reached the limits of what could be communicated by body language—he, huddled under the desk with his arms protectively cradling his head upon his knees, and she, precariously leaning over the desk, peering intently at him. She finally paused. “Dr. S.,” she said plaintively, “sometimes I feel you don’t take me seriously!” “Sure I do,” he replied, “but sometimes I get overwhelmed.”

Relief washed over me as I realized that nothing could shake the bond between these two, who had known each other all of their lives—not even honesty.

—A rheumatologist from Richmond, Virginia

## Last Rites

I SAT IN A FAMILY MEETING WITH THE husband and grown children of a patient who was dying of lymphoma. The husband, a retired social worker, had worked professionally with many dying patients. I began to ask him, “How can I be most helpful to you?” but even before I finished the question, I could see the rage building in his face.

“Don’t give me any of that palliative care crap,” he thundered. “Just do your job!” There was a heavy silence in the room. His daughter murmured, “Oh, Dad, you don’t need to yell.” But obviously he *had* needed to yell. And at that moment I needed to sit silently with them, red-faced.

The next morning I learned that the patient had died during the night and that the husband had apologized for his behavior. He had appreciated our care. I, of course, wondered whether I should have been the one to apologize.

—A palliative care physician from Chicago, Illinois

## STEEL YOURSELF

WHEN VINNIE PULLED A HUNTING knife out of his satchel and started stabbing the air, it was about 7:35 in the morning, five minutes into his therapy session. We were in my small office down a long and at that hour largely uninhabited corridor.

Vinnie’s sidekick of many years, Rhonda, had just made off with his modest cash reserves. Vinnie had taken pains to show her where the stash was and to warn her not to touch it. He knew that she was sinking further and further into cocaine abuse. How could he not have known what she would do as soon as she had the chance?

Fresh from discovering the inevitable, Vinnie was in a rage that played right to the last row of the balcony. I was, however, front row center and far closer to the knife than I cared to be. My efforts to calm the storm were unavailing. I lowered my voice, softened my demeanor, and watched Vinnie veer closer and closer to the edge of his psychic stage. Then from somewhere in my consciousness, I recalled how one of my teachers had said that a patient’s agitation can be made worse by a physician’s steadfast calm, for the patient is left to feel abandoned to the inner storm. Feeling like an utter fool, I lifted halfway out of my chair and started yelling what a horrible thing Rhonda had done. The effect was nearly instantaneous. Vinnie deflated into his chair, let the knife dangle, and started talking a modicum of sense. A moment later, I observed, in my usual voice, that the knife made me uncomfortable, and Vinnie quickly put it away.

—A psychiatrist from Cambridge, Massachusetts



## Whoops a Daisy

SOMETIMES A THREAT IS NOT from violence but from love. He was a homeless man who heard voices and came to the clinic to see me each week in an effort to sort them out. Money for cigarettes and food came from cans he collected from the trash before dawn. He was too suspicious to accept government support. There was no one for him but me.

A few months into his visits, something strange began to happen. Fifteen minutes before each appointment, an arrangement of flowers arrived in my office. There were roses and birds of paradise, snapdragons and exotic things. The delivery boy staggered under the size; the bouquets were so large you couldn't see around them. There was no card.

I knew the sender and why he sent them. It was gratitude and a bribe, his heart for all to see. But it was all wrong. For one thing, he had no money. For another, we were a clinic for the destitute; floral arrangements flew in the face of poverty. And technically—which was to say, in terms of psychiatric technique—I couldn't accept his gifts: it would have been like accepting his



erotic proposal. But refusing them would have been like breaking his heart. The day he showed up with a crystal bud vase, action was required. He came into the office and put the vase on the desk. I closed the door and stood next to it.

"Mr. N.," I said, "about the flowers." I felt like I was drawing blood for the first time.

"You like them?" he asked. "They're no big deal." (*I love you, only you.*)

"They're beautiful. But you can't send any more."

"Don't you like 'em?" (*What did I do wrong?*)

"Of course. But you can't send them."

"How come?" (*Don't I mean anything to you?*)

Here's where wisdom should have spoken—part frankness, part empathy, an expensive explanation that left him informed but cared for. "It's against the rules," I said. It was the cheaper road to take. His face fell. "So no more flowers," I added.

"Against the rules," he said. He thought for a sad moment, then brightened. Now he understood. "No more flowers," he said. "Sure. Next week, a fruit basket."

—A psychiatrist from Boston, Massachusetts

## NOT ON THE SIDE OF THE ANGELS

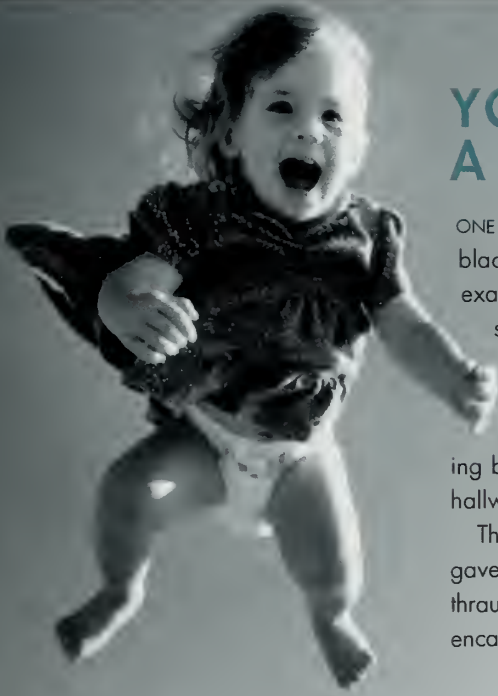


EVEN SOME 25 YEARS AGO, LYNN, A ONCE-PROUD city north of Boston, had become a haven for people down on their luck and the criminally inclined. It was in that rough community that a young black man had gotten romantically involved with the white girlfriend of a member of the motorcycle gang Hell's Angels. In retribution, gang members stormed the man's apartment and proceeded to carve him up, along with his friends. When I arrived on the scene late that afternoon, the carnage was incredible; some were dead while others were suffering from large stab wounds from knives violently thrust through bones, ribs, and even sternums.

The victims were transported to the hospital, where Hell's Angels were camped outside the entrance, astride idling motorcycles and with menacing stares. They would sometimes rev their engines or race their bikes around the perimeter of the hospital; a few times they even tried to storm it. The police seemed powerless, though they were eventually able to provide us safe passage through the gauntlet of bikers. Because charges had not yet been filed, the bikers were acting within their legal rights, thus threatening the integrity of the hospital and the safety of all of us.

Inside, the stabbing victims and their families could hear the constant revving of motorcycle engines. Once the patients were stabilized, we began to plan their transfer to safer institutions. Not surprisingly, no other hospital was





## YOU'VE COME A LONG WAY, BABY

ONE DAY EARLY IN MY PEDIATRIC INTERNSHIP, I NOTICED THAT SOMETHING WAS blocking access to my next patient, who was waiting for me on the exam table. I looked down to find the patient's baby sister sleeping soundly in her carseat. Smiling, I grasped the handle and gently swung the carseat a couple of feet to the left. But the baby was not buckled in, and the handle was not latched into place.

As soon as I lifted it, the handle rotated against the seat, launching baby sister into flight. Three feet later, she landed face first in the hallway, right in front of my preceptor.

The baby would prove to be fine, and her mother—remarkably—forgave me. But I'll never forget that horrible feeling of watching a baby fly through the air. It reminds me to take nothing for granted in any clinical encounter—not even my ability to avoid dropping the patient.

—A pediatrician from Baltimore, Maryland

eager to accept them. Finally, we moved two of the more stable patients under police protection and made arrangements for the rest. The remaining patient, who was the principal focus of the Hell's Angels' wrath and whose injuries were the most severe, could not be moved. I insisted on police protection for him around the clock.

The Angels eventually disappeared to their country hideout and the patient was safely discharged. I continued to see many of the victims in my Salem office, including the man who had been the main target. He and his family were grateful, and I felt a bond with them. I could not hope to understand the experience of being young, poor, and black, but I had certainly shared their fear. Even so, the striking contrast between their terror in the besieged hospital and my escape each day to a comfortable home in a white, suburban neighborhood will haunt me forever.

—A thoracic surgeon from Danvers, Massachusetts

## Loose Lips

AT FIRST I VIEWED HIM AS A GOOD CASE—NO, A GREAT CASE, WITH a social history hardly ordinary. Felony armed robbery was his specialty, his life sentence having been imposed after a third conviction. He told countless stories—of prison life, of stickups and con jobs, of raps beaten. He had been released to die in our hospital when his prison doctors certified that he would never beat this rap—pancreatic cancer.

Initially I was eager to hear the stories, to be invited into his dark world. But I grew sick of it, found the sociopathy invidious, this patient reprehensible. It wasn't merely that I didn't like him. I began to abhor him, much as one abhors a wife beater or child molester. And until that point in my professional life, I had never hated a patient.

When he became delirious from pain medication, he began to babble unchecked about the unsolved crimes for which he prided himself, delighting especially in the midnight heists at the turnpike gas stations with a partner still not apprehended. Yet incredibly, his babbling would abruptly cease whenever he sensed the presence of a cop—a caution not lost upon the police frequenting his bedside.

Here I was then, with a human being I detested, oath-bound to care for him, to attend to his suffering, to respect his confidences. Imagine my ambivalence when the police asked me to wear a wire.

—A cardiologist from Augusta, Maine



# **SPECIAL** operations

*A surgeon trained  
in the secret  
maneuvers of the CIA  
recounts his role in  
the Korean War*

■ ■ ■

BY THOMAS G. PARKER





**IN** THE WINTER OF 1950, DURING MY SECOND YEAR OF SUR-  
gical training at Massachusetts Memorial Hospital  
in Boston, I volunteered to join the Air Force and  
soon received orders to report for active duty once  
my training year ended. Then, unexpectedly, one of  
my surgical professors, Reginald Smithwick '25, summoned me to his  
office—an unusual event of either great or terrible implication.

When the Korean War erupted in the summer of 1950, just five years  
had passed since the end of World War II. The United States found itself,  
once again, in an urgent military situation and faced with an armed forces

**SECRET AGENT MAN:**  
Thomas Parker '49  
went from a surgeon-  
in-training to a CIA  
recruit in the early  
days of the agency.



doctor shortage. Younger physicians in the reserves were called up to active service shortly after the onset of battle, and the Doctor Draft Act quickly became law.

When I received the summons to my professor's office, I could not have guessed that I was about to be swept up in these events. As it turned out, a fellow academic surgeon in Washington, DC, had made an inquiry of Smithwick: Did he know of any young surgeons who might be interested in special, classified duty with the Department of Defense? Well, I thought, when Smithwick made his pitch, why not? I was 25, single, and adventuresome.

The next day I met with a Dr. Gibson. The former gastroenterologist displayed a sharp sense of humor and yet a businesslike demeanor. Gibson revealed few details except to inform me, rather cryptically, that I would be taking on a medical, classified assignment with the Department of Defense and that he would be in touch shortly. I was instructed not to mention our meeting to anyone, and we exchanged no written information beyond names and phone numbers. One call later, roundtrip plane tickets arrived for a prearranged rendezvous with Gibson in our nation's capital.

Upon my arrival in Washington, Gibson drove me to a Navy building on E Street, which he identified as Central Intelligence Agency headquarters. I had never even heard of the CIA. Over the next 48 hours I underwent exhaustive testing, orientation, interviews, poly-

graphs, and a medical checkup. I received repeated reminders not to reveal my new affiliation to anyone, family included.

Not long afterward, my Air Force assignment mysteriously changed, and I received new instructions to report to what turned out to be a mythical Pentagon office. This "office" was actually just a mail drop. The change in orders was my last written communication. After that, we conducted all business by telephone.

In the summer of 1951 I did indeed report to a new, secret life in Washington, where "the Company" made things move quickly and smoothly. The perks included a lieutenant colonel equivalent GS-19 salary grade: the rather princely sum of \$1,800 monthly. This was no small comfort to a guy who had previously been earning \$25 a month.

The CIA, then in existence as an agency for only two years as the successor to the Office of Strategic Services, labored under huge growing pressure from the Korean War. Many Ivy League graduates were secretly recruited, but I was the only doctor there as far as I could tell. For three months, we underwent eight hours of training a day in security, strategies, geopolitical issues, clandestine techniques, and assorted spy tricks. We learned how to set up a safe house, create a mail drop, and carry out a "dead drop," whereby we hid a document at an unmonitored site for later pickup by another agent. We were taught how to copy a key on a



**I** learned to shoot a .45-caliber revolver and a 30 mm carbine. I also learned six different ways to kill a man using only my bare hands.

wet blotter, how to ascertain whether a door had been opened by closing a paper match in its hinge, and how to mangle. My favorite malingering sleight called for us to hide some venapuncture or animal blood in the mouth, then, when a pressing situation arose, to writhe dramatically and spew blood on the nearest enemy.

This was serious business with a bright, highly motivated crowd. And, of course, the curriculum marked a dramatic change from my surgical training, with its emphasis on learning to help people rather than to deceive them. We were eventually team-tested in downtown Washington; one final drill tasked us to obtain a certain document from a particular commercial office. We were warned that the CIA would deny any knowledge of us if we got caught. The police arrested one team but its members were quickly released by a federal judge's mysterious order.

spot, with parachutes drooping against the 250-foot tall structures. They were the unlucky souls who had drifted the wrong way when released from the free fall training towers. A rescue sergeant always seemed to be on his way up to help disentangle the men. No one earned merit points for tower hanging.

One of my most memorable moments there occurred as I was walking under the beginners' jump platform, where soldiers were engaged in making their very first jump. They wore parachute harnesses rigged to cables that rolled them downhill to a soft landing. On one end of the platform stood a few young servicemen shouting at the top of their lungs to the sergeant down below, "I'm a coward, a chicken shit coward! I balked, I didn't jump!" They kept repeating this mantra, their humiliating penalty for hesitating to obey a jump command.

**COMBAT READY:** Facing page: Parker (right), his aide, Lee Won Woo (center), and a corpsman pose in front of an ambulance scrounged off an Army Motor Pool sergeant. Left: Parker stands at the ready to treat casualties of parachute training jumps gone awry.



I volunteered to go to Korea for one year because assignments at other stations usually lasted two years. I was sent to Fort Benning in Georgia for a fortnight, where I had the dubious honor of participating in the jump school, hand-to-hand combat, and weapons management courses—not what I had envisioned as part of my medical mission. I persuaded the authorities that I did not need the full tour, yet I still learned to shoot a .45-caliber revolver and a 30 mm carbine, to carry a 100-pound backpack, to eliminate an enemy with a knife by thrusting rather than slashing, and to make a proper landing after bailing out of an airplane. I also learned six different ways to kill a man using only my bare hands.

At Fort Benning, a soldier or two always seemed to be clinging helplessly to the jump towers at some high

### A Long Way from Home

Just before Christmas of 1951, I arrived at a U.S. Air Force base in Atsugi, Japan, where the CIA occupied a high-security, isolated compound that housed uniformed personnel from all the services. Although no signs announced a CIA presence, the diversity of personnel, mix of uniforms, presence of civilians and women, and absence of Japanese personnel suggested that it was not just an American Air Force base, as the entrance sign claimed.

The Korean War was the first "international" conflict sanctioned by the United Nations. More than 20 countries sent personnel, all of whom served under the United Nations flag. American troops rubbed shoulders with Greek, Belgian, Turkish, British, French, and Australian soldiers. The Swedes ran a hospital; the Danes, a hospital ship. In reality, however, it was mainly an American effort, as evidenced by some 37,000 Americans who died there. It was a unique war waged by diverse, free men, and we learned much from each other.

My new station was located just outside of Pusan at a Korean hot spring resort, which had been commandeered and now bore an Air Force "cover." Its tiny medical unit had been started by a bewildered Navy doctor who was all too happy to leave. With it came a fine Korean lad, Lee Won Woo, then 23 years of age,

**I** was called on the field phone by a young CIA case officer asking how many morphine syrettes it would take to kill someone.

without whom I could not have done much. He was reserved at first, but we soon earned each other's respect. We were together about 20 hours a day for a full year, and we found that we shared a remarkably similar philosophy even though we came from hugely different societies and faiths.

### Undercover Medicine

My job was to provide medical support to everyone from household staff to covert agents operating in North Korea. We supported a number of clandestine training camps headed by Republic of Korea (ROK) senior officers. We all were feeling our way and it was uphill work. One night I was called on the field phone by a young CIA case officer asking how many morphine syrettes it would take to kill someone who was going to be buried alive; the doomed man had been convicted of being a double agent. We guessed six, and the traitor was "mercifully" buried with morphia. I also witnessed an ROK commander, in view of all his trainees, formally execute a double agent with a pistol shot to the head. This was all a long way from New England and I lost 20 pounds in the first two months.

"The Company" had full access to everything, and my support from Washington was superb. More than once I had to use a medical hot line (my pseudonym was Andrew J. McElfresh, taken out of the Dublin phone book). I had to deport an older full colonel who was behaving dementedly, a Navy lad who was gay, and a lieutenant colonel who fractured his femur during a jump he had been expressly warned not to make.

I also rendered medical care to ROK commandos, who were sometimes injured while blowing up bridges or making parachute landings. They arrived by truck, helicopter, or ocean luggers in strange ways and at strange times. We had dispensaries at our U.S. and ROK training sites, where we treated common ailments. Major trauma required a hospital and I had top-secret authority to admit anyone—including Koreans—to any U.S. facility. At odd hours, this took some convincing of medical duty officers at U.S. Army hospitals and U.S. Navy hospital ships. None of these facilities was near the combat zone.

Once I did an appendectomy on the commanding officer of an island training camp. I operated out in the open sun with the assistance of instruments boiled by wood fire and a corpsman. Thank goodness, the spinal

worked. When I revisited that camp, you would have thought I was the president of Korea.

### Spies Awry

The intelligence community included some fascinating people. One U.S. Air Force sergeant had a personal cadre of about 20 Korean men whom you did not want to cross. They manned two eight-ton native fishing boats off the eastern coast of the South China Sea. Below deck, they hid a destroyer's firepower with recoilless 80 mm cannons and weapons of all kinds. They would sail north, change the flag at the 42nd parallel, and proceed to cut telephone cables and blow up bridges. Then there was a British Major Kitkat (clearly not his name), who would appear with a wounded man or two (we never asked questions) and then disappear, only to repeat his mission in a month or so.

But sometimes events did not go as planned, such as when a CIA case officer and his pilot went down in a "sterile"—that is, unidentifiable—C-47 airplane deep inside China. They were on a top-secret mission to pick up a defecting communist Chinese official as part of Operation Skyhook, a highly classified CIA maneuver used to snatch people from the ground by slow, low-flying aircraft.

In this maneuver, a ground team would stake two 20-foot-tall "goalposts" joined by a nylon snatch line. They would then affix the snatch line to a harness that the escapee wore while standing with his back to the flight pattern. The plane would fly in low and slow enough so that its grasping, self-tightening hook would sweep between the poles, snag the lift line, and whisk the escapee into the air. To prevent G forces from tearing the man apart, the system relied on a sensing winch spooled with 800 feet of nylon rope of good stretching capacity, which immediately reeled out against the resistance. Then it would slowly reverse and the man would be reeled up into the plane.

Following the crash, the 21 year-old CIA case officer was a prisoner for 20 years in China. On my return to the United States, I had the awkward duty of informing his widowed mother that he was dead. We did not know, in fact, whether he was dead or alive or even what had happened. We simply stuck to our cover story of a plane going down in the South China Sea. Until the officer's capture was known, a U.S. submarine dutifully waited near a previously designated Chinese land point on the last day of each





**SPY KIDS:** Parker unlocks a gate to the fenced-in clinic he helped cobble together to treat neglected Korean civilians, especially children.

month, as per the agent's Escape and Evasion Plan—another CIA specialty. When President Nixon opened diplomatic relations with China, the case officer was finally released. He lives today in Connecticut with a Chinese wife—truly a fine man and unsung hero, who has never written about the misadventure that cost him 20 years of freedom.

### Close Encounters

Part of my job was to care for U.S. personnel who were, at times, a rowdy bunch. Their complaints ranged from lacerations to fractures to sexually transmitted diseases. One of my great triumphs was getting a 50-by-25 foot clinic built on the nearby United Nations Civil Assistance Command compound by providing an Army quartermaster major with off-the-record treatment for gonorrhea. I then traded two cases of medical Scotch for a winterizing kit, which allowed us to run the facility year-round. I was also able to find a Korean doctor and nurse to staff the clinic for Korean civilian patients, whose only access to medical care had been at the beleaguered local facilities.

I traveled to campsites mostly by bad dirt roads and wore out two jeeps during my tour. As we had lost some personnel in guerrilla actions, my superb aide, Lee Won Woo, always wore a sidearm, and I always carried a 9 mm Beretta in a hidden shoulder holster. And we certainly did not want to travel at night. In fact, the

United Nations train making the journey between Pusan and Seoul was frequently targeted by guerrilla snipers during its overnight run. Passengers were actually assigned weapons for the trip, and each numbered seat had a designated 30 mm rifle stored in a wall rack. The train had three open, sandbagged stations at the front, middle, and rear, each equipped with a manned .50-caliber machine gun. I sometimes felt as though I had stumbled onto the set of a Hollywood Western.

One afternoon, some 40 miles from Pusan, Lee Won Woo and I were driving home from a camp. We came upon a small farming community with a large U.S. military truck and two GIs surrounded by 50 or more angry Koreans. One distraught citizen cradled a three-year-old child in his arms. Woo ordered the people to step back and told them that I was a doctor. When I confirmed that the child was dead, the four of us suddenly found ourselves in a menacing situation as the crowd closed in tighter around us. Without warning, Woo flipped out his .45-caliber revolver and fired two rounds into the air. The crowd backed away as I hustled the two GIs into our jeep. Woo rode shotgun while I drove until we reached a safe distance. I have no doubt that, tragically, the child had darted out into the path of the truck. I am indebted to my courageous aide, as were the unlucky corporal and private.

### Coming In from the Cold

By the time I returned to the States after my year of service in Korea, the CIA had matured amazingly. And it now has a complex medical support system. But we helped give it a jump-start way back when. I was indeed happy to have survived this powerful experience and to resume my surgical training in August 1953. I was newly married and the future had never looked brighter.

Fifty years ago, I signed a contract, a copy of which I never owned, promising neither to publish nor to reveal any information about the CIA. After recently receiving clearance from the CIA allowing this article to go to press, I am delighted to be able to share my memories of this extraordinary adventure with my old friends and colleagues, who thought I was just behaving peculiarly back in 1951. ■

*Thomas G. Parker '49 practiced general and thoracic surgery for 34 years in San Mateo, California, and was associated with Stanford Medical School.*



AMONG THE RUINS: Medical relief workers pause from their duties to survey the site of tragedy.

*“Nothing in my life’s experience—not my surgical training, not the time I spent operating on children caught in the crossfire in the Gaza Strip, not even the television news coverage of the Twin Towers disaster—could have prepared me for what I witnessed at Ground Zero.”*

—JAY J. SCHNITZER



# Ground Zero

A member of one of the Disaster Medical Assistance Teams reflects on the despair—and lessons—of the September 11 tragedy. *by* JAY J. SCHNITZER

**I**TALY WAS MY INTENDED DESTINATION ON September 11. But instead of flying out of Logan Airport to attend a medical conference in one of the world's most tranquil settings, I found myself driving down to New York to help deal with the aftermath of one of humankind's cruelest disasters.

That morning, I had been sitting in my office at Massachusetts General Hospital when a staff member poked her head in the door to say that a plane had just crashed into one of the World Trade Center towers. Within moments, everyone in the office was glued to the surreal images on our television screen. By noon, we had received word that all four Boston-based Disaster Medical Assistance Teams were to be deployed to New York. And by six that evening, we were on our way.

With our caravan of rented vehicles—flying, of course, was not possible—nearly 70 of us—doctors, nurses, paramedics, emergency medical tech-

nicians, security personnel—headed toward Stewart Air Force Base near Newburgh, New York, to await further instructions. We arrived at two in the morning and bedded down for the remainder of the night on assigned cots in a large hangar. Tensions were running high, and we all desperately wanted to do something, no matter how small, to help those who had been hurt.

At dawn, we awoke surrounded by nearly 3,000 personnel, both civilian and military, from throughout New England, who had arrived overnight in preparation for further deployment. The disaster response leadership at first believed that the World Trade Center would be a mass-casualty scenario. They had decided to set up additional emergency personnel at the air force base to staff a triage and evacuation hospital. Tragically, we would soon realize that the World Trade Center was a mass-fatality disaster. Within the first few hours of the attack, all of the initial survivors had been triaged to New York City and surrounding hospitals. Those who could be treated were; the rest had been killed.

## The Walking Wounded

Within 24 hours, it was obvious that the disaster response teams would not be needed to treat wounded patients from the site. Rumors flew, and we feared that we would soon be disbanded and sent home, having done nothing. As a physician, I have seldom felt so helpless and frustrated. Yet we soon learned that we were to provide emergency on-site medical care to the rescue workers—the firefighters, police officers, and ironworkers who were frantically digging through the acres of smoldering rubble in lower Manhattan. Suddenly we



**MAKESHIFT MEDICINE:** The Disaster Medical Assistance Teams treated 4,215 patients on site.



**RING OF HOPE:** Medical workers set up five stations around the perimeter of the "pile" to care for rescue workers.

had a new mission. We were deployed to New York City on Thursday at five in the morning—the first Disaster Medical Assistance Team to arrive.

We were initially assigned to Chelsea Pier, where we spent the day with frustratingly little to do. By Thursday evening, however, a group of us were moved downtown in police vans to a location much closer to Ground Zero to set up the first medical station. Between midnight and six in the morning, we set up our station in the courtyard of a community college. It was pitch dark, the rain was pouring, and the wind blew fiercely, but we felt little of it; finally, we were *doing* something. Although our mission had now become one of support rather than rescue, we embraced it eagerly.

By dawn on Friday, our unit was up and running, and we had taken over medical care of the rescue workers from volunteers at the local high school a block away. Our team of approximately 30 people worked the first shift in the tent, and we subsequently organized a series of rotating eight-hour shifts with three other teams.

The New York City Fire Department and Emergency Medical Services then decided to place advance teams closer to the actual site, and five medical stations were set up in a perimeter around the "pile," as the site of the Twin Towers had come to be known. Some were in tents and one, surreally, in what had once been a delicatessen, with the neon "pizza" sign still flickering.

Most of our patients were the "walking wounded"—rescue workers with eye irritations, foot injuries, upper respiratory symptoms, and minor wounds. We also saw patients with serious medical problems or trauma. Each shift, we transported to local emergency rooms three to six rescue workers with complaints of chest pain and shortness of breath. Many of these were retired personnel with cardiac histories who, despite warnings not to do so, came to work on the pile anyway. We also treated a small number of victims of falls, explosions, flash fires, and burns. All of the workers were exhausted and subjected to enormous, unabated stress. Within two weeks of the first medical station's becoming operational, disaster response teams had cared for 4,215 patients, as many as 600 a day.

As a hospital-based surgeon, I found myself deeply impressed by the skill and cool-headedness of the paramedics and emergency medical technicians. I saw them manage difficult airways, stabilize patients, and set up intravenous fluids under the most trying of circumstances. Unflappable—despite the poor lighting, dropping temperatures, rain, wind, fire, smoke, and even falling debris—they set an example for all of us.

At Med Station 2, the grim odor of decaying flesh that permeated the air offered a constant, sickening reminder of the deadly toll. This station was set up in the lobby of the American Express Building, next to which sat a large, white tent that served as a temporary morgue. This facility was staffed with morticians who had been brought in from around the country to deal with the overwhelming number of corpses and body parts being recovered.

During a quiet spell on one of my shifts, I spoke with the police sergeant stationed at the entrance to the mortuary tent. A stoic, middle-aged man, he had been preparing to head home after working the night shift when the first frantic 911 calls started coming in over the police radios. He had rushed to the scene to help extricate as many people as possible before the towers collapsed. He then dug in the ensuing rubble for many more hours straight through until, exhausted, he finally returned home briefly. There, he had broken down and cried before returning to his beat, now one of the largest disaster sites in history. He had lost friends and colleagues, whose remains, no doubt, passed by him as they were transported to the makeshift mortuary, where he stood mournful guard.

### On Hallowed Ground

Even as we focused on the task of treating the thousands of patients who streamed through our stations, it was difficult not to be overwhelmed by the hellish devastation that lay right outside our tents. Nothing in my life's experience—not my surgical training, not the time I spent operating on children caught in the crossfire in the Gaza Strip, not even the television news coverage of the Twin Towers disaster—could have prepared me for what I witnessed at Ground Zero with my own eyes.



*“Even as we focused on the task of treating the thousands of patients who streamed through our stations, it was difficult not to be overwhelmed by the hellish devastation that lay right outside our tents.”*

—JAY J. SCHNITZER

My first night there, I stood at the edge of the pile and gaped at the staggering destruction and carnage before me. The skeleton of the buildings, now iconic in everyone's mind, loomed over the acres of smoldering ruins. A 100-foot tall communications antenna that had once perched atop one of the towers, a quarter mile high in the sky, now lay directly in my line of sight at ground level.

My first stunned impression was that this could not possibly be real; surely, this was an incredible Hollywood set. The dazzling lights that Con Edison had set up on high poles illuminated the scene with an otherworldly intensity that reminded me of a night game at Fenway Park. Yet the brightness seemed grotesquely incongruous with the mass grave that lay beneath the rubble. As I stared, mesmerized, I realized it was all too real.

We were standing on hallowed ground, and everyone treated the site with the respect it deserved. Firefighters gingerly picked their way through the smoldering, smoking pile of twisted steel, debris, dust, and human remains. Rescue workers dug gently with hand tools—no heavy equipment was allowed at this stage—in the desperate, vanishing hope that they might find a survivor in the rubble. I watched a nurse trying to console one of the rescue dogs, who was visibly distraught.

As physicians, we, too, sometimes shared the hopes—and disillusionments—of the rescue workers. Shortly after midnight a few days into our mission, I was the supervising medical officer on the overnight shift at Med Station 2. I found myself standing at the windows, staring at the rubble yet again. The night was cool and cloudy; the drizzle earlier in the day had stopped, and everything glistened wetly in the artificial light. Suddenly my paramedic team leader ran over to me. “Someone thinks they saw a hand move on the east side of the pile—they want a surgeon on-site stat!” I grabbed my emergency pack and raced to the area where the Urban Search and Rescue Team was operating. There the team leader stood, looking dejected. “It was only a piece of metal stripping moving in one of the holes,” he said. “We sent in the dogs and the fiberoptic scopes, but no one was down there.” For a few precious minutes, hope and excitement had flared; then instantly everyone dissolved into despair again.

We remained in the rescue phase of the operation for several more days, although hope was quickly fading. It was not until our team departed, ten days after the attacks, that the mission officially became one of recovery.

### Out of the Ashes

The events of September 11 will no doubt mark for this generation what the John F. Kennedy assassination represented for mine: a tragic watershed moment. But that day has also given those of us in the medical profession valuable insights into our future. We learned that our country's disaster response system works. It is solid, but it is not perfect, and we must incorporate what we have learned into future planning.

We also learned that flexibility is essential. Plans and situations change rapidly, unexpectedly, and frequently. We have to be able to adapt moment by moment. We learned as well that job descriptions are often irrelevant in the face of disasters. As a surgeon, I spent more time in a hard hat and work gloves than I did in a scrub cap and sterile O.R. gloves.

And yet I saw that we, as physicians, can do a great deal to help people, even under austere circumstances and with imperfect tools. At Ground Zero, we had no x-ray machines, laboratory facilities, or fancy diagnostic equipment but nonetheless managed to do good work just by relying on clinical skills and judgment.

Perhaps most important of all, I saw that people's capacity for good is still greater than their capacity for evil. The heroes of this tragic story were the firefighters, police officers, and ironworkers. The images of these men and women gently, somberly, and respectfully removing human remains day after day—often to the point of collapse—will stay with me forever. It was my profound privilege to work with these extraordinary people, who stood as a constant and much-needed reminder of human decency, compassion, and sacrifice. ■

Jay J. Schnitzer '83 is a pediatric surgeon at Massachusetts General Hospital and a member of a Boston Disaster Medical Assistance Team.

**SPLendor ON THE GRASS:** The marble used in the construction of Harvard Medical School's new home in 1906 was originally intended for the New York Public Library. The marble was rejected as being not white enough, however, and the contractors for Harvard Medical School acquired it at a bargain price. In the end, more exterior marble was used for the Quadrangle buildings than had been used in Boston in 20 years.





# LA BUILT TO ST

IN THE MARBLE  
SPLENDOR  
OF BUILDING A,  
THE SIXTH  
ADMINISTRATIVE  
HOME OF  
HARVARD  
MEDICAL SCHOOL  
HAS PROVED TO BE  
ENDURING  
BY NORA N. NERCESSIAN



# ANATOMY OF 'A' BUILDING

**I**N MAY 1899, THE PRESIDENT OF HARVARD University, several members of the Harvard Corporation, and a few medical faculty members arrived at the home of John Collins Warren on Beacon Hill to discuss one of the most ambitious schemes ever proposed by an academic group with depleted resources: the construction of a grand new medical school with its own hospitals, estimated to cost millions. The proposed plan aimed not only to relocate Harvard Medical School from Boylston Street to Longwood Avenue, but also to enlarge the size of its facilities and their outreach in an unprecedented manner. ■ Warren, whose ancestors had played a pivotal role in the founding and growth of the School since 1782, would not compromise. For him and the handful of faculty members committed to the move, bringing research and hospital facilities to one centralized space was imperative because, they believed, proximity between laboratory bench and patient bedside was needed more than ever. ■ The medical faculty, intensely committed to the new plan on Longwood, was able to secure the means to purchase a 26-acre plot that would accommodate the Medical School, the Dental School, and two hospitals on the Ebenezer Francis estate. Despite the University's conservative financial policies, by June 1900, Harvard President Charles Eliot had accepted the idea of the School's relocation to the Francis estate. ■ The great financier J. Pierpont Morgan provided funding for the administration building and two of the four laboratory buildings. By most accounts, the first meeting between Morgan and the faculty members lasted only five minutes. Frederick Shattuck, the Jackson Professor of Medicine, would later write that Morgan strode into the office, looked at the architectural plans lying on the table, and said, "Those are good-looking buildings. How much will the administration and the two adjoining buildings cost?" Without receiving a definite answer, he added, "Send me your architects. Good morning, gentlemen."







## PLAN INTO ACTION

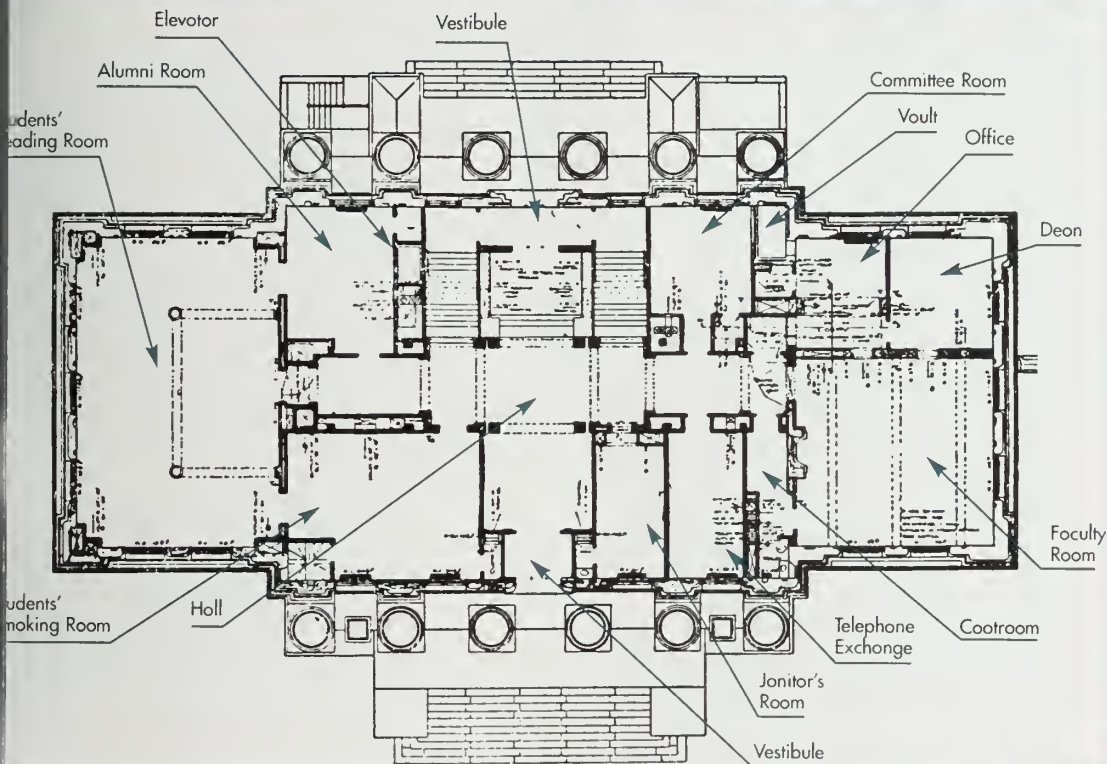
**A.** The site of the new buildings in 1903.

**B.** The plan of the first floor of Building A in 1906.

**C.** At the time of the dedication in 1906, Henry Pickering Bowditch (seated), the first full-time professor of physiology in the United States, and John Collins Warren, the first Moseley Professor of Surgery.

**D.** Construction in progress in June 1904.

**E.** William Lambert Richardson, the first HMS dean to occupy offices in Building A.



# MEETINGS 'ROUND THE CLOCK

**I**n 1950, Mrs. Robert De W. Sampson, a great-granddaughter of Benjamin Waterhouse, presented HMS with a grandfather clock. Waterhouse, one of the founders of Harvard Medical School, had originally received the clock as a gift in 1790.

The Waterhouse Clock was installed on the first floor of Building A in the Faculty Room, which was renamed the Waterhouse Room. Because the clock was too short to allow for its running a full year on one winding, the bottom of the clock was cut out and holes were punched in the floor through which the 50-pound weights could sink.

In December 1950, the University marshal instituted the annual winding ceremony at the School's traditional Christmas party. The ceremony continued into the 1960s when medical students and their teachers would gather at a party in the Waterhouse Room and take turns in raising the heavy weights that kept the grand clock ticking.

**WIND-UP JOY: From 1950 into the 1960s, HMS students and faculty members would wind the Waterhouse Clock at the annual Christmas party.**



## An Oasis in Marble

Land was first broken for the buildings in September 1903. By then, several plans had been considered. But the plan finally adopted had four large buildings facing an open Quadrangle, with the administration building majestically at the head. A corridor running through the basement of the administration building, but on the first floor of the others, connected all of the buildings.

Crowds gathered to watch the construction of the buildings as they slowly transformed the swamp of the Francis estate into an oasis of classical grandeur. Besides the architectural style and massive size of the new structures, the material out of which they were built set them apart from their environment. In the original plan, the buildings were to be constructed of modest brick with granite trimmings. But one of the bidders, Norcross Bros. Co., proposed to substitute luxurious marble in place of limestone for the exterior of the buildings. The marble Norcross offered had originally been intended for the construction of the New York Public Library, which was in progress in 1902. But because the marble was not totally free of color, it had been deemed "unsuitable" by the architects of the library and therefore became available at a discounted price. In the end, more exterior marble was used for the buildings around the Quadrangle than had been used in Boston in 20 years.

Long before his dedication speech, President Eliot had chosen names for each of the five Quadrangle buildings. His choice of Hippocrates and Galen for the administration building inevitably placed a special significance on the building and a moral responsibility on those who would inhabit it and shape its mission in the years to come. Yet the building came to be widely known by the letter "A," as designated in the original architectural drawings.

## The Students' Path

When the new buildings finally opened, the 304 medical students enrolled were,



by their sheer numbers, the main occupants of Building A, a fact that was evident in the amount of space devoted to them. The first floor housed the Students' Smoking Room, the Students' Reading Room, and the Alumni Room, which served as a club room for both alumni and students. Within the Reading Room was the Library, where a gift from alumni formed the nucleus of the collection and contained works of daily use by students. The Library had started with plans to become "more perfect than any in America, as soon as circumstances will permit," and contained the Faculty Collection—publications and manuscripts of all the professors who had ever taught at the School. The three rooms offered the only common space for students in the Quadrangle until 1927, when Vanderbilt Hall began operations and provided a common room for student use.

Two marble staircases, then as now, led to the hall on the second floor, which was devoted to lecture halls and classrooms. At the head of the staircase, the student would find two classrooms, each with two raised platforms: one equipped with a blackboard where the instructor stood, the other for lanterns.

Projection was on the wall over the blackboard or on screens that unrolled from a canopy near the ceiling.

To the right of the classrooms was the Amphitheater for Surgical Lectures. The lower level of this room, where the lecturer stood, was connected with a Preparation Room, so that specimens could be transported directly from the museum above on movable tables. Also on the second floor was a large lecture room for Obstetrics, Theory and Practice of Medicine, which was connected to two Preparation Rooms.

### A Heavenly View

From the teaching area on the second floor, two staircases led to the vast expanse of the Grand Hall, which, with its galleries, occupied almost half of the vertical elevation of the administration building, projecting a space altogether different from the floors below. That effect was achieved through the translucent vault that ran across the width of the building, the glass openings all around the vault, and the windows in each alcove of the two galleries and the Grand Hall. Together, they allowed light to penetrate

the building, transforming the interior of the entire upper half of the building into an almost otherworldly space.

Here, on the third floor, and spreading over the two galleries above, was the Warren Anatomical Museum, with its extensive collection of 11,000 medical instruments and anatomical and pathological specimens. The museum was a major teaching resource for students and faculty. Established in 1847 with the personal collection of the first John Collins Warren, the Hersey Professor of Anatomy and Surgery from 1815 to 1847, it chronicled changes in medical education, practice, and instruments. Upon retirement, Warren donated approximately 600 items to the University, along with an endowment of railroad stock worth \$5,000 for the museum's continued maintenance and improvement.

The medical faculty and physicians across the country sent many more specimens. Most were preserved in large glass jars, from which they could be removed for study or demonstration. But topping the list were the remains of the former Hersey Professor himself, John Collins Warren, who had willed that after his postmortem his "bones be carefully pre-



**VIEW LOOKS MARBLEOUS:** Vista from the Greek portico of Building A after the construction of Avenue Louis Pasteur.

served, whitened, articulated, and placed in the medical College near my bust; affording, I hope, a lesson useful, at the same time, to morality and science."

Activities in the Warren Anatomical Museum slowed down during World War I. New activities were restricted, expenses curtailed as much as possible, and the museum closed to the general public. At the end of the war, the museum received a large number of specimens from the battlefield, showing the effects of bullet wounds to the head and the lesions of "gas gangrene." It also became a repository of war memorabilia, including a German bomb that had fallen in a French hospital that had been staffed by the Harvard men of Base Hospital No. 5.

More relics would arrive after the end of World War II, during which the School prepared for possible German attacks. A number of faculty members were charged with security duties. Particular care was taken for the Library, where the stacks were to be fitted with a fire door. In addition, a large number of security officers were posted around the buildings, which were better lit to protect against "possible enemy damage."

### Changes in the Air

Although all of Building A was transformed during the course of the twentieth century, the first areas to undergo change were the first and second floors, due to the expansion of the Library in 1928. In its new and expanded setting on the second floor, the Library became the repository of memorabilia that connected the School with world events. At the entrance to the Ernst Room, on the opposite side from the Civil War Tablet, hung a large bluish-green slate listing the names of HMS alumni and faculty

who had died in the service of their country during World War I. Another war memorial was designed in 1947, this time for faculty members and alumni who lost their lives in World War II.

The changes brought about a shifting of the space dedicated to students. In 1928, space was set aside as a women's rest room, which, the dean informed the department heads, any secretaries or technicians were welcome to use. Later, following the admission of the first group of women as students at HMS in 1945—which occurred after almost a century of debate—a Women Students' Room was added in the basement.

Transformations in the Warren Anatomical Museum had started by the mid-1940s, when offices were added to the Grand Hall and when the expansive skylights had been covered as a war-time security measure. In later years, new teaching methods would diminish the museum's usefulness

as a primary teaching resource. Gradually, in part because of increasing demands within the School for more research, classroom, and administrative space, some of the museum collections were put into storage and eventually transferred to other institutions. The museum survived, in different forms and shapes, for more than 90 years in Building A. It would reemerge in 2000, only in part, in the Warren Museum Exhibition Gallery in the Francis A. Countway Library of Medicine.

In the late 1960s, Building A, like the School and the country at large, witnessed the dilemmas and pain caused by dramatic events—the Civil Rights Movement, the Women's Movement, and the Vietnam War. Just as the building had been a repository of the events of the two world wars earlier, it was transformed, for a short time, into a forum where stu-

dents expressed their views on medical ethics, the curriculum, and politics.

### The Gordon Hall of Medicine

In 2002, nearly 100 years after the original marshland was transformed into a premier center of medical education and research, the administration building has been rededicated as the Ellen R. and Melvin J. Gordon Hall of Medicine. The skylight running across the east-west axis of the building has reopened to the light after more than half a century of obscurity. The area beneath the skylight, once the Grand Hall, has been rededicated to the Academy, a program aimed at advancing the School's teaching mission.

As the Academy retrieves the teaching mission of Building A, the landscape around Gordon Hall resounds with preparations for the new interdisciplinary science of tomorrow. The buildings surrounding Gordon Hall on the original Quadrangle, now called the South Quad, will be renovated to accommodate the new ventures inspired by the rapid pace of molecular biology.

Beyond these, the Quadrangle has already begun to expand on Avenue Louis Pasteur, north of the parapet walls and beyond the Circle of Tugo. From Gordon Hall, the vista toward the Fens will soon include the new research facilities of the North Quad, where ground was broken in February 2001—nearly a century after a similar ceremony took place on the other side of the Circle of Tugo—and which, HMS Dean Joseph Martin explained, "will embody the spirit of cooperation" with the communities surrounding Harvard Medical School. ■

*Nora N. Nercessian, PhD, is assistant dean of alumni affairs and special projects at HMS. This article is excerpted from her recent book, A Legacy So Enduring: An Account of the Administration Building at Harvard Medical School from Its Foundation to Its Rededication as the Gordon Hall of Medicine. A limited number of copies of the book are available from the author; please contact her at 617-432-1560 or nora\_nercessian@hms.harvard.edu.*



**RADICAL FORUM:**  
During the spring of 1969, strike posters plastered the columns of Building A.



# THE HALLS OF MEDICINE



A

## AN INSIDE LOOK

A. The Library on the first floor of Building A in 1923.

B. A view of the Warren Anatomical Museum in 1906.

C. The marble staircase leading to the second floor of Building A in 1906.



C



B



Donald W. Bickley

**1937** "After 67 years of active practice, I made my last two house calls on August 31, 2001. My office then became 'The Cedar Valley Hospice Home.'"

Paul H. Liljestrand

"I finally retired at the age of 90 from the Hawaii Chamber of Commerce Charitable Foundation awards committee, which is still giving away money originally raised to fight the 1898 plague. Because of the way the fund was set up, contributions continued to be made long after the plague was eradicated. Millions of dollars were later transferred into a fund for the health of the people of Oahu. For 50 years, I've been able to go to monthly committee meetings and help give away the money."

Conrad M. Riley

**1938** "I went on a Yale- and Harvard-sponsored cruise to Greece and Turkey last April and found myself the only octogenarian there. My wife and I enjoyed every minute."

Carl E. Taylor

**1941** "I continue to teach and do field research—August in Tibet, October in Peru, and two field trips to the Indian Himalayas—my main source of healing after the death of my wonderful wife, Mary."

James E. Kreisle

**1942** "Natalie and I visited Cully Cobb and his wife, Cathy, at their home on Old Hickory Lake near Nashville in October 2001. Both are fine. Cully is active in sailboat racing."

Robert J. Glaser

**'43B** received an honorary Doctor of Science degree from the

Watson School of Biological Sciences, a degree-granting education program of the Cold Spring Harbor Laboratory, at a convocation celebrating the 111-year history of science education at the laboratory. Glaser was recognized for his effective leadership as director for medical science and trustee of the Lucille P. Markey Charitable Trust.

Lewis A. Barness

**1944** was honored at a celebration tribute held in Tampa, Florida, in February. The ceremony, which honored his commitment to medical education for almost six decades, included a day and a half of scientific symposia. Until 1988, Barness was founding chairman of the Department of Pediatrics at the University of South Florida School of Medicine.

Chester C. d'Autremont

"In March I became the grandfather of triplets, all doing

very well. Their mother, my daughter Sloan, is the other MD (pediatrics) in the family. Bragging rights to being first-born go to the girl. The other two are boys."

Evan Calkins

**1945** has opened a rheumatology consulting practice in association with his daughter, Joan Calkins, a pediatrician and pediatric rheumatologist. The office is located in Hamburg, New York, the village where the Calkins family has lived for the past 40 years. "It is a joy to work together," Calkins writes.

Stuart H. Q. Quan

has been honored with the first Recognition Award of the Northeast Society of Colorectal Surgeons. Quan is an internationally recognized expert in malignancies of the colon and rectum. Upon retirement after 51 years of service to Memorial Sloan-Kettering Cancer Center, Quan is emeritus attending surgeon at







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